

The University of Chicago

HOSPITAL MALPRACTICE INSURANCE

A DISSERTATION SUBMITTED TO THE FACULTY
OF THE SCHOOL OF BUSINESS IN CANDIDACY
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

1942

By
GERHARD HARTMAN

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PRELIMINARY STATEMENT

HOSPITALS are now recognized as indispensable agencies in the proper care of the sick. From the institutions of fifty years ago established almost solely for charity, hospitals have developed into modern organizations receiving an increasing proportion of income from payments by patients and intended to be more or less self-supporting.

The function of hospital management is the promotion of the economic welfare and security of hospitals, consideration being given to the needs of the patients applying for treatment and to the avowed purpose of the hospital as declared in its constitution. The complexity of the organization and the diversity of needs and interests (present) demand particular attention to the application of administrative skill and judgment in financial matters. Unless proper executive direction and control are exercised to co-ordinate carefully operations and plans, the result is confusion, waste, and the disruption of the operation of the institution.

To the public and to businessmen, grounded in the principles of regular economic enterprise, hospitals are peculiar institutions. Most hospitals charge for service, yet they are not primarily concerned with making a profit. Many professional people work in hospitals, yet they are not generally considered to be the hospitals' agents. The confusion is heightened by the general lack of comprehension of the auspices under which hospitals operate. Governmental bodies—federal, state, county, and city—operate general hospitals, in addition to spe-

cial hospitals for tuberculosis, mental diseases, etc. Voluntary hospitals, on the other hand, are essentially community enterprises operating on a nonprofit basis and are controlled by religious, fraternal, or nondenominational bodies. Proprietary hospitals, as the name denotes, are private enterprises for which capital was supplied by individuals, usually one or more physicians, and which operate under charters giving permission legally to withdraw profits, should any be earned. There is also frequent misunderstanding regarding the degree to which these different types of hospitals are liable for their torts and acts of negligence. From the legal point of view the rights, privileges, and duties of hospitals range from one extreme, where the hospital, being a public or governmental enterprise, is not liable in its own name, to the other extreme, where the hospital is a proprietary endeavor and is held liable in the same degree as any private, corporate enterprise. Somewhere between these extremes are the hospitals organized as voluntary, nonprofit associations, quasi-public in character, whose legal status has been interpreted differently in many states. It is this last group and the proprietary hospitals which are of major concern in the study of malpractice insurance.

In view of the misunderstandings which are common to most people outside the field and to many in the field, it is considered desirable to describe some of the more important characteristics of hospitals in order to avoid confusion about the fundamental bases of hospital organization and operation.

When compared with business enterprises, it is found that close analogies exist between hospitals and other types of enterprises, such as hotels, manufacturing concerns, and educational institutions. Hospitals resemble hotels in that they give board and lodging to people in return for payment but differ from them in that they render skilled services for remedial care. Health is not a commodity which they can sell across the counter at some predetermined price. The attitude of the hospital patient in contrast with that of the hotel guest further differentiates the two enterprises. Hospital pa-

from similar diseases, require different care and treatment.

Hospitals resemble educational institutions in that they are the places of learning for the professions of medicine and nursing. The growth of specialization in medicine has contributed materially to the use of hospitals for educational purposes.

One way to appraise hospitals is to look into the amount of capital invested. Analyzed according to the three types of legal control, namely, governmental, voluntary nonprofit, and proprietary, the total capital investment for all hospitals

TABLE 1*
TOTAL CAPITAL INVESTMENT FOR ALL HOSPITALS AND FOR GENERAL AND SPECIAL HOSPITALS IN THE UNITED STATES

Type of Hospital	Total	General	Special†
Governmental.	\$1,416,540,000	\$ 415,635,000	\$1,000,905,000
Voluntary nonprofit.	1,404,415,000	1,224,338,000	180,077,000
Proprietary.	269,168,000	208,793,000	60,375,000
Total.	\$3,090,123,000	\$1,848,766,000	\$1,241,357,000

* Source: C. Rufus Rorem, *The Public's Investment in Hospitals* (Chicago: University of Chicago Press, 1930), p. 27.
† Including tuberculosis, mental, and institutional.

tients are unwilling recipients of the services, fearful of the uncertain cost which they are usually unprepared to meet and apprehensive of the physical pain they endure.
The analogy between hospitals and manufacturing concerns is valid in so far as they both make large investments in plant and equipment and hire many types of skilled and unskilled personnel. But there the comparison stops, for hospital service cannot be channeled into the mold of large-scale production methods where identical, repetitive processes and procedures prevail. The application of modern production methods is far more limited in hospitals than in business, for patients, even when suffering

and for general and special hospitals in the United States is as shown in Table 1.
Inspection of the table reveals that hospitals as economic enterprises represent a capital investment which places them among the five leading groups of industries. Since voluntary hospitals are among the primary subjects of this study, it is important to note that they have a total capital investment of almost one and one-half billion dollars and that this capital was provided with no expectation of receiving a profitable return on the investment and with no prospect of reimbursement for the principal. This means that such institutions are really social enterprises, the property of the community.

Examined in terms of the number of hospitals and beds in relation to capital investment and arranged in classes by control, the results given in Table 2 are obtained. From these data it is evident that the distribution of hospitals, beds, and capital investment under the type of control is not equally proportioned. A number of factors contribute to this unequal distribution. Governmental hospitals, while they have higher average bed capacities, have a smaller capital investment, since the diseases treated do not require the elaborate building and equipment needed in the care of general medical diseases. In governmental hospitals for the mentally ill, custodial care is provided, while voluntary and proprietary general hospitals must give more individualized care of a remedial nature. Proprietary hospitals, compared with voluntary hospitals, are larger in number but have relatively smaller bed capacities. While over a third of the total number of hospitals are under proprietary auspices, they contain less than one-tenth of the total beds and capital investment. Measured in terms of bed capacity and capital investment, therefore, voluntary hospitals constitute the more significant group.

Since part of the premium for hospital malpractice insurance is computed by every company on the basis of a bed charge, it may be important to attempt to derive a minimum estimate of the total premiums which would be paid if all voluntary and proprietary hospitals purchased this insurance. Assuming a basic rate of \$2.00 per bed as the model charge for all voluntary hospitals and \$8.00 per bed for all proprietary hospitals, the estimate of the total annual premium for voluntary hospitals would be over one million dollars. A later chapter dealing with rates discloses that most companies

also have other charges, such as those based on the number of physicians and surgeons, pharmacists, X-ray operators, ambulance drivers, and the use of radium, so that the estimate given here is obviously an understatement of the probable cost to hospitals.

One of the knotty problems with which hospital administrators must deal from time to time is the claims of patients for damages arising from alleged injuries suffered while receiving care. The issues which arise from this problem have to do not only with the internal operation

TABLE 2*

NUMBER OF HOSPITALS AND BEDS IN RELATION TO CAPITAL INVESTMENT, BY CLASS OF CONTROL

Type of Hospital	No. of Hospitals	No. of Beds	Capital Investment
Governmental..	1,813	567,434	\$1,416,540,000
Voluntary non-profit.....	2,604	247,970	1,404,415,000
Proprietary.....	2,435	77,530	269,168,000
Total.....	6,852	892,934	\$3,090,123,000

* Source: Rorem, *op. cit.*, p. 36.

of the hospital but with such diverse matters as professional staff relations, community attitudes, the psychology of patients, and the law. It is the purpose of this study (1) to analyze these factors into their component parts, (2) to interpret the fundamental issues from the best available data and sources of information, and (3) to propose solutions for them.

Owing to the lack of published material on this subject, it was found advisable to go directly into the field, interviewing persons participating actively in this branch of insurance work, as well as gathering information through correspondence. To requests for advice and

assistance in this subject, replies were received ranging from offers of wholehearted co-operation to complete refusal to divulge any information. Fortunately, the former group predominated.

In order to maintain a high ethical level and an attitude of fairness throughout this study, no mention is made of the name of any insurance company or hospital in relation to specific data or cases.

The effort has rather been made to conceal the identity of these organizations, for it was felt that nothing would be gained toward an impartial study of the conditions in this highly specialized field by specific disclosures. Observations have been made solely for the benefit of insurance companies and hospitals, and no intentional bias has been directed toward any organization or group.

CHAPTER I

INTRODUCTION TO THE PROBLEMS

THE problem of hospital malpractice insurance from the point of view of hospitals is essentially the administrative one of determining whether hospitals should bear the malpractice risk or whether they should transfer it to some agency more able to bear it efficiently and economically. When separated into its component parts, the problem divides into a number of issues which involve hospitals, patients, and the general public, and which may also relate to insurance companies if they are selected to assume the risk. These separate issues may be stated as follows:

1. What is the nature of hospital malpractice risk?
2. What methods can be employed by hospitals to reduce or eliminate malpractice risk?
3. What services do insurance companies offer hospitals in insuring against this risk?
4. How extensive is the coverage provided by existing insurance contracts?
5. What are the premiums charged, how closely do they approximate losses, and how sound are the bases upon which they are determined?
6. What kinds of claims arise most frequently and how are they related to the cost of defense and settlement, the size of the hospital, the quality of services rendered by hospitals, and the frequency with which they occur in different states?
7. What is the present status of charitable institutions with respect to legal liability?

The answers to these fundamental questions, while of primary concern to hospitals and insurance companies, are of importance to the public in a number of respects. Recognizing the term "public" in its broadest aspect, it may be di-

vided into four interested groups, namely, the injured patient, the courts of law, the state insurance departments, and the various communities. Each has some concern in these matters.

The injured patient, of course, wishes to be compensated for his injury, and most hospitals on their part are sufficiently public-minded to wish to make fair redress for injuries sustained in receiving care. The community is interested in so far as it really owns the capital investment in voluntary hospitals and must look to these hospitals for the care of its sick. If that care is crudely rendered and injuries due to negligence by hospital employees result, the public, in the last analysis, must pay the bill either through increased charges or by meeting operating deficits. The courts are concerned, for, when claims arise and suits are filed, they must hear the injured claimant's plea and decide whether there are grounds for suit. If the answer is in the affirmative, and there is a basis for further legal action, the court must be prepared to decide upon what legal bases or doctrines the patient can recover or the hospital deny the right to recovery. The state insurance departments are involved, since they are intrusted with regulating certain practices of the insurance companies doing business within their borders. Most insurance departments, however, have not given particular attention to hospital malpractice insurance, since the premium volume in any individual state is too small to deserve a great deal of consideration when com-

pared with life, fire, automobile liability, and workmen's compensation insurance. In New York State it was recognized that the relation between coverage provided by different companies and the rate charged was apparently not well reasoned or justified. The employee of the department charged with the job of preparing this comparison, however, was handicapped by his lack of familiarity with the technical terms used in hospitals and found apparently insurmountable difficulties in preparing an analysis which was significant.

The problems evolving from hospital malpractice claims are not of particularly recent date, but their exceptional growth in importance during the last ten or fifteen years is correlative with the increasing importance both economically and socially of the hospital as a community institution. This has resulted in new conceptions concerning the possibility of losses arising from claims alleging negligence or malpractice. With the more enlightened approach, the courts have rebelled against the antiquated and inhuman doctrine which held that hospitals were not liable for injuries to patients because funds granted for the care of the sick could not be diverted to the payment of individual damages. They are now examining the facts surrounding the alleged act of malpractice more critically, not with the view of protecting the hospital's funds and resources, but in the light of public policy.¹ As is characteristic with the law, the changes are not uniform; they are the diverse opinions of jurists in many states and sections. Therefore, the legal aspects of this subject are at present in a state of flux, with few settled or unanimously approved concepts.

No actual figures exist for the total number of malpractice claims arising in the United States during any given year. The only available data for claims are those which the twenty-odd insurance companies writing malpractice insurance possess, but these figures are incomplete in two important respects. First, they do not include the claims of those hospitals which do not carry any kind of malpractice or liability insurance to cover injuries to patients, and this is a fairly large group, even in metropolitan communities. Second, figures on actual malpractice claims do not reflect the number of unreported, but nonetheless real, claims arising from injuries sustained by patients who do not make any claim against the hospital. The number of these is doubtless quite large. Various reasons exist for refraining from presenting justifiable claims. Two which may be most influential are (1) the satisfaction which the patient feels with the general hospital service which has been rendered, plus the recognition that it was an unavoidable accident, and (2) the fact that many people are sufficiently generous and understanding of the public service aspects of hospital care to be willing to accept remedial care for the injury without any additional financial compensation.

The writing of malpractice insurance, from the point of view of insurance companies, presents a somewhat unique problem. The executives whom they employ are, by and large, men trained in the field of insurance but not particularly conversant with the policies and problems of the different types of hospitals. This is not intended as a reflection upon the insurance companies writing this line, since all but a select few write a very small volume of hospital malpractice insurance and since there is no need on

¹ Leading cases supporting this view are presented in chap. vii.

their part for highly specialized personnel to deal with hospital problems.

Hospital malpractice insurance is an "accommodation" line to most companies. This means that the companies refuse to accept a hospital for this particular kind of risk unless they are permitted to write all the other risks against which the hospital may insure, namely, boiler explosion, public liability, elevator liability, food products liability, etc. The theory behind this, as expressed by some insurance executives, is that the excess losses which may be incurred in writing the malpractice line, about which little concrete evidence or statistical experience data regarding costs of claims is available to the greater number of companies, will be absorbed by the other lines, which presumably are more profitable or, at any rate, for which more reliable data are available. The extent to which this argument is true will be discussed later.

In order to determine whether the problem of hospital malpractice insurance is of consequence to individual hospitals, a comparative cost analysis of hospital malpractice insurance in relation to other forms of insurance usually purchased by hospitals has been made. The information was obtained by direct inquiry from a number of voluntary and proprietary hospitals. All premium charges have been reduced to the one-year term common for hospital malpractice insurance.

The first case is that of a proprietary hospital of approximately 50 beds, located in the South Atlantic region. The premium for hospital malpractice insurance was over \$350, the most expensive single insurance charge. This hospital has also purchased workmen's compensation, fire (based on the depreciated value of the building and equipment), elevator, fidelity and surety, and boiler-explosion in-

surance. Hospital malpractice insurance comprised 35 per cent of the total premiums paid.

Another instance is that of a voluntary hospital of approximately 50 beds, located in the Middle West. The premium for hospital malpractice insurance was almost \$200, the largest single insurance item. Workmen's compensation was the next most costly item, followed by fire (based on the original building cost), windstorm and tornado, public liability, and elevator liability insurance. The cost of hospital malpractice insurance was more than 25 per cent of the total annual premiums paid.

Further cases include a voluntary hospital of approximately 100 beds under the auspices of a church. The cost of hospital malpractice insurance was almost \$200, again the largest single item. Compared with the total insurance cost, which included workmen's compensation, windstorm and tornado, fire (premiums based on original cost of building), boiler-explosion, and elevator liability insurance, the hospital malpractice insurance premium was over 35 per cent of the total.

In a university voluntary hospital of more than 250 beds, located in the eastern part of the country, the hospital malpractice premium was in excess of \$1,200—over 35 per cent of the total premiums paid for defensive or liability insurance. The case of a voluntary hospital of more than 350 beds, also located in the East, may be cited as another example of the relative cost of hospital malpractice insurance. In this case the cost of the hospital malpractice insurance was found to be more than 25 per cent of the total insurance cost, after excluding the payments made to the state-operated workmen's compensation insurance fund.

It is quite evident that hospital mal-

practice insurance costs are proportionately higher than other types of insurance coverage and, in some cases, higher than all other individual premium charges. Therefore, hospital superintendents, who are responsible for meeting all kinds of risk, will be particularly concerned with the problems related to hospital malpractice insurance.

A variety of factors has contributed to the growth of hospital malpractice claims, and, while these will be explored more fully later, they may well be mentioned here. No neat and logically precise evaluation of the significance of each can be made, for they will vary among different states, hospitals, and between rural and metropolitan communities. One vital factor contributing toward the seriousness of the malpractice problem has been the introduction of modern diagnostic and therapeutic mechanisms and techniques. (A more or less necessary corollary of this has been the employment of inadequately trained practitioners and technicians until the time lapse between the introduction of the equipment and the training of the personnel has been fully achieved.) As an illustration, mention can be made of burns due to X-ray or radium, from which result serious claims that are frequently difficult to defend. The same sort of problem is found in industry, where the introduction of complex machinery has resulted in new types of industrial accidents. These are particularly prevalent during the earlier period of introduction, when workers must learn new operations and when satisfactory safety mechanisms have not yet been devised or installed. A second factor is the consideration that hospitals which were formerly pure charities in the actual sense of the word as well

as in the legal sense are now accepting paying patients, which in the eyes of the law has prejudiced their favored position with respect to liability. A third factor, not directly related to the above, is one which may, for want of a better word, be called the growing "commercialism" of hospitals. When hospitals lease space to florists, candy shops, notion stores, privately owned and operated pharmacies, etc., they are simulating the activities of commercial enterprises, such as hotels. No disapproval of such practices is intended, but hospital administrators should be aware of the possible public and legal implications of such a course. The trend toward commercialism is much more pronounced in some sections of the country than in others. The growing claim consciousness of the public deserves mention. The attitude of the courts toward hospitals has changed in matters pertaining to liability. The previously secure position of charitable hospitals has been attacked repeatedly in past years, and, if the same tendency continues, hospitals will receive progressively less protection under the old rulings from the courts. Lastly, economic problems of hospitals have reflected upon internal operations and upon public relations in innumerable ways, often tending to increase the malpractice risk. For example, when a hospital is hard pressed for funds, it cannot reduce its expenditures as readily as most industries. Hospital costs tend to remain fixed, and, if any paring process is to be followed, the tendency is to reduce current expenditures for plant repairs and to reduce the quality of personal service rendered. One of the more frequent methods by which service is restricted is to reduce the nursing staff, particularly in the private pay-patient division. This may be a satisfac-

tory adjustment where the private patients can afford and desire to employ private-duty nurses, but it works a real hardship on those people who can afford to pay only for private accommodations and no more. Therefore, under a restricted private patient nursing service, the patient who does not employ his own

nurse receives inadequate nursing care, with the result, as will be shown later, that the door is opened wider for injuries to patients and to consequent claims.

All these factors are present in determining the increasingly serious position of hospitals with respect to malpractice risk.

CHAPTER II

NATURE OF HOSPITAL MALPRACTICE RISK

THE extensive variety of injuries which patients may use to bring charges of malpractice against hospitals, as well as against physicians and nurses engaged in hospitals, presents serious difficulties in the study of the risk involved. Before attempting to analyze the problems of risk, a distinction must be drawn between the meaning of risk in everyday usage and risk in the technical sense. As used by most people, risk is considered subjectively to mean "taking a chance." However, in the technical sense it means the uncertainty of the occurrence of an undesired event involving definite financial losses. It is in the technical sense that it will be used throughout this paper. In referring to risk, it is important to remember that the term is directly related to uncertainty, which is more or less a measurable quantity of the lack of knowledge concerning future events. When considering the number of patient days' care rendered and the number of visits to the out-patient department, provided that the hospital operates one, it would be reasonable to assume that, as each of these factors increased in numerical importance, there would be an upward tendency in the malpractice risk. However, there is no reason for believing that this would be a proportionate increase, for countervailing features may be introduced. The larger hospitals can departmentalize their activities along functional lines, thus gaining the greater efficiency of specialization. Having better-trained department heads to supervise and control

activities, especially those pertaining to patient care, also produces an appreciable reduction in the malpractice risk.

The types of diseases treated definitely condition the quantity of risk. Surgery is considered to present more opportunities for claims than medicine. Diseases requiring long confinement in the hospital or resulting in impairment of a patient's normal capacities involve added hazards. Additional dangers arise with the therapeutic use of possibly dangerous physical or chemical agents. Finally, there is the risk involved in the amount of experimental or investigative research practiced on patients.

First among the considerations amenable to administrative control which affect malpractice risk is the selection, training, and supervision of hospital personnel. From time to time leaders in the hospital field have called attention to the often crude and elementary personnel techniques used in many hospitals. Not infrequently employees are hired because they will work at a minimum or substandard salary and not because they are particularly capable or desirable. From the employee-management point of view there are certain distinct barriers which limit the hospital's ability to get the best employee for the job.

Besides the financial considerations already mentioned, there is also the organizational factor. Hospitals are necessarily broken up into many departments, which makes it difficult, if not prohibitively expensive, to attempt to centralize personnel supervision and control. How-

ever, administrators should take cognizance of the importance of employees, not solely because of their capacity to produce, but also because of the danger in which the hospital is placing its patients, and, in the last analysis, itself, by permitting improperly qualified employees to work in the hospital.

Perhaps the generally low level of employment conditions and employee stability in hospitals can be best shown by a survey of hospital labor turnover made by the United States Department of Labor.¹ This survey disclosed that the average rate of turnover among unskilled labor in hospitals was 588 per cent. This figure is many times higher than that for industry. While it is true that orderlies, ward helpers, and certain housekeeping employees are the only personnel classified as unskilled who are in frequent, direct contact with patients, the above figure indicates the general seriousness of the hospital labor problem. As each new employee is hired, he must not only be trained in his particular duties and responsibilities but, what is more important, must become oriented and conditioned to a new and complex environment where errors in judgment and performance may have very serious consequences.

The second controllable factor is the professional staff. In hospitals this includes physicians and nurses. The influence of physicians upon risk will be considered first.

For many years the American College of Surgeons has been promoting the adoption and use of modern methods in hospitals. This has been done through what is known as the hospital standardization program. The careful thought

and study which have been devoted to this subject have been formulated into a concise statement known as "The Minimum Standard," with the purpose of presenting the essential requirements of a hospital for approval by the American College of Surgeons. The general subjects with which "The Minimum Standard" is concerned include (1) a definite organization of the medical staff; (2) the general qualifications of physicians who may practice in the hospital; (3) the adoption of rules, regulations, and policies by the hospital board governing professional work in the hospital and the development of staff meetings; (4) the writing of accurate and complete case records for all patients (these to be filed in the hospital); and (5) the use of essential diagnostic and therapeutic facilities under competent medical supervision.² A hospital bearing the stamp of approval of the American College of Surgeons will have gone a long way toward establishing satisfactory operating conditions with the physicians who practice within its walls and may be looked upon as a more desirable malpractice risk than one which has failed to achieve approval.

There are a number of additional elements which have some bearing upon the influence of physicians on hospital malpractice risk. In an indeterminable but significantly large number of cases the first idea of presenting a claim for malpractice occurs to the patient by reason of some careless word or action on the part of a member of the hospital medical staff. This is likely to happen in hospitals, as contrasted with private practice, since more than one physician may have an interest and direct hand in the care of a single case. Instead of the usual family

¹ "The Problem of Labor Turnover in Hospitals," *Monthly Labor Review*, November, 1927, pp. 131-32.

² Malcolm T. MacEachern, *Hospital Organization and Management* (Chicago: Physicians' Record Co., 1935), p. iv.

practitioner being the only one to look after the patient, as is generally the case in nonhospitalized illnesses, interns, residents, and other physicians have a part in the professional care of a patient. Frequently physicians are called into consultation, and, unless extraordinary precautions are observed, they may speak carelessly of medical matters within the patient's hearing. It is a familiar fact to those who have worked in hospitals that patients are keenly alert to any statements concerning themselves. No matter how harmless these comments may seem to professional people, they may provoke an unfavorable interpretation by the patient and result in charges of malpractice.

In hospitals where there is friction and professional jealousy among the physicians there is likely to be an increased malpractice risk. When one physician informs a patient that his former treatment under another doctor was improper, that physician is opening the way for a malpractice suit which may involve the hospital.

Finally, in their relations with physicians, hospitals suffer from the lack of control of surgery and the specialties. The medical practice acts of the various states permit licensed physicians to practice general medicine and any specialty in which they feel competent. The sole judge is the physician, for at present there are no adequate professional or legal barriers prohibiting licensed physicians from setting themselves up as specialists in most of the medical fields. The resulting uneven quality of care rendered may contribute materially toward hospital malpractice risk.

Nurses are second to physicians in the hospital professional hierarchy. Historically, their duties and responsibilities have multiplied, and they now render services of a fundamentally professional

nature. The character of their work is such as to require attainment of skills which can come only from careful preparation and training. They relieve the physician of time-consuming, routine tasks and must be able to observe physical signs and symptoms and record them accurately. In accordance with instructions from physicians, they administer medicines and medications. But what is more significant from the risk aspect is that the nurse must be able to build up the patient's and family's confidence in the physician and in the course of treatment prescribed as well as in the good quality of the hospital services rendered. Nurses give the greater share of patient care, far surpassing physicians and other hospital employees in the number of hours given to direct attendance upon patients. It is this last factor which makes them extremely important in the study of malpractice risk.

Generally, there are two essential elements which are significant in conditioning malpractice risk from the nursing aspect. One is the proportion of graduate nurses in relation to student nurses. The other is the supervision of nursing operations and performance. These elements are interrelated. A hospital using a large number of student nurses who are carefully supervised and not expected to perform in circumstances where they are not qualified may be a much better risk than a hospital which uses graduate nurses exclusively but employs them from hospitals or schools teaching fundamentally different techniques. It follows that one of the best ways to guard against malpractice claims is to have a stable staff of graduate nurses familiar with the hospital's professional methods and nursing routines and to have student nurses under capable and adequate supervision during both the day and the night.

The degree of modernization of hospital buildings and equipment determines the presence or absence of certain hazards. Generally, it is true that, the more antiquated and outmoded a hospital's plant and equipment, the greater is the malpractice risk. For example, old X-ray equipment with exposed contacts carrying electric current presents shock hazards which are absent in the newer, shockproof apparatus. But new equipment does not necessarily remove dangers. It may aggravate them, particularly if the equipment is difficult to operate, mechanically complicated, or unfamiliar to personnel. A surgeon or one of his assistants may wish to alter the position of an anesthetized patient on an operating table. A complicated mechanism may so fully absorb his attention that he may not notice the patient's hand near the moving parts of the apparatus, with the possible result that the hand may be cut or crushed.

Records do not have any direct bearing upon the causes of malpractice claims, but they do play a significant part in the hospital's defense when claims arise. Too much stress cannot be laid upon the vital need for accurate and complete records. If a hospital hopes to deal effectively with claimants and their legal representatives, it must be prepared to give evidence of the full nature and character of the services rendered. Only complete medical histories, accurately recorded, can tell this story months, and sometimes years, after the services have been rendered.

Outside the hospital's sphere of influence but directly affecting malpractice risk is the growing "claim consciousness" of the public, intensified by the efforts of so-called "ambulance-chasing attorneys." Many people who would formerly have hesitated to become involved in

malpractice suits are now willing to press such claims, based on actual, exaggerated, or fictitious injuries, in the hope of gaining a few dollars. This condition, not traceable to any decrease in the level of hospital operation or efficiency, has been aggravated by the activity of attorneys whose former sources of revenue have been closed by the enactment of workmen's compensation laws. These circumstances vary in intensity in different communities, but they have a prominent place in the current picture of malpractice risk.

The factors influencing risk have been presented above in separate, distinct groups, as if each operated singly and independently of the others. This, of course, is not always the case. Risk may be determined by the interrelations of these factors in innumerable combinations. For example, the important factor of supervision over professional and non-professional personnel is determined to some extent by the form of the hospital building. A hospital which is broken up into many small units for patient care, with an insufficient number of properly designed nurses' stations and an inadequate number of telephones, will present added problems of supervision in patient care and may result in increased malpractice risk.

It is impossible to elaborate all the probable combinations of factors which may and do arise and to assign an accurate weight to each. But there is one way of getting a rough approximation to such information, and that is through the statistical analysis of the distribution of claims of malpractice, by cause, in hospitals.

The United States Fidelity and Guaranty Company of Baltimore has published a table of the claims which it has received (Table 3). The data are based

on "an experience of five years including all classes of general medical and surgical hospitals, large and small," voluntary and proprietary, "all of these institutions, however, having been approved for insurance after due consideration of their sound standing in view of the capability of staff, professional employees, equipment and operation."³ Each of the

TABLE 3

ANALYSIS OF RELATIVE DISTRIBUTION
OF MALPRACTICE CLAIMS

	Per Cent
1. Burns, hot water bottles or packs, poultices, drugs, or ice packs.....	23.0
2. Major or minor operations, including anesthetics and hypodermics.....	17.7
3. Wrong surgical or medical treatment or diagnosis.....	10.0
4. Self-inflicted injury—insane or delirious.....	10.0
5. Self-inflicted injury—sane..	10.0
6. Violet or X-ray, radium, radiant heat, or alpine lamp..	8.5
7. Maternity cases, mother or child (excluding deliveries, which are under No. 2)....	7.7
8. Surgical dressings.....	2.4
9. Miscellaneous.....	10.7
Total.....	100.0

groups of claims presented in the table involves a number of the general considerations mentioned above as determining malpractice risk and reveals the complexity with which these factors may be combined.

However, the table is so constructed that it cannot be used as a careful guide in the approximation of hazards. Examined critically, it becomes evident that

the second group, "Major and minor operations, including anesthetics and hypodermics," is too inclusive, making it appear disproportionately large. Alleged malpractice arising from care during deliveries has also been included in the second group—an unsound practice for purposes of distinguishing claims arising in general surgery from those in the field of obstetrics. In the fourth and fifth groups the term "self-inflicted injury" would seem to denote that the patient had intentionally mutilated himself. Such is not the case. A more correct term to use would have been "injury arising from negligent care," for the claims contained in these groups refer to such causes as falls from beds or in bathrooms while unattended and injuries while delirious. The sixth group, concerning injuries from violet or X-ray, radium, radiant heat, or alpine lamp, are all burns which should be a subgroup of the general class of burns heading the list, thus reflecting the extreme seriousness numerically of this cause of malpractice. Finally, the miscellaneous group is too large to permit critical study. It represents over 10 per cent of the total claims and should have been subdivided into its component parts.

The United States Fidelity and Guaranty Company points out that, "in considering this table, it must be remembered that it is based upon the relative number of cases, not their individual seriousness, importance, or difficulty of defense. They are numerous enough to show the gravity of hospital liability, as they represent 131 cases in a total of about 323, an average total of 65 hospitals insured in each of five years."⁴

³ *Professional Liability Insurance for Hospitals* (Baltimore: United States Fidelity and Guaranty Co.), p. 2.

⁴ *Ibid.*

CHAPTER III

METHODS OF MEETING MALPRACTICE RISK

IT is the problem of management to study risks, including malpractice, and to determine what proportion of risks the hospital will bear, what proportion it will attempt to eliminate, and what proportion it will transfer to professional risk-bearers. Only by a careful study of possible combinations of risk factors in the internal operation of the hospital can an administrator estimate the amount of risk which his institution presents. Such an analysis should lead directly to the consideration of significant measures of elimination. Elimination is one of the most fundamental means available to administrators for reducing the malpractice risk and, in the past, one of those most often neglected. A serious study of past experiences within the hospital with regard to accidents to patients and the resulting claims of malpractice, both threatened and actual, may indicate current defects and practices which are conducive to the development of future claims. A more comprehensive examination of data derived from other hospitals may suggest possibilities of future difficulty as yet giving no trouble. Little has been done toward constructive attempts at elimination, and to this deficiency may be attributed to some extent the rapid increase in hospital malpractice claims.

Pursuing the study of risk, hospitals must prepare to meet threatened financial loss as well as to deal with the problems of legal defense when claims arise. The latter is especially important. The adequacy and competency of the legal counsel and defense has a controlling in-

fluence on the financial outcome when claims are pressed.

One way in which a hospital can meet malpractice risk is to attempt self-insurance. This should not be confused with merely bearing the risk, for self-insurance involves definite preparation to meet the losses and expenses arising from malpractice claims by setting aside certain hospital funds as reserves.

The practice of insuring hospitals with private companies is followed almost universally. The question may be raised, however, whether carrying insurance in this manner is a paying proposition. The continued increase in hospital expenditures is causing boards and administrators to reduce expensive items wherever possible (sometimes tempting them to decrease insurance costs). The tendency to object to the cost of insurance is due partly to the fact that the malpractice losses of particular hospitals have often been very low as compared with the cost of insuring. Therefore, it may be worth while to consider the question of establishing group hospital insurance funds to insure hospital risks, or at least those which may be safely insured in that manner. While this paper is concerned with the problems of hospital risk relative to malpractice, the following discussion of self-insurance is applicable to some other risks, such as fire, elevator liability, public liability, and workmen's compensation.

Examination of the relative advantages and disadvantages of group self-insurance as against private company in-

surance brings out some of the following arguments.

ADVANTAGES

1. The policy of carrying insurance as a matter of commercial prudence against the possibility of a large claim destroying the concern because it cannot be met from the company's assets does not appear to be so absolutely essential for voluntary hospitals for the reason that a possible fatality does not exist in the same degree for such hospitals. A community hospital seldom ceases to exist and would not necessarily be completely without the power to secure further resources in order to continue rendering services to the community.

2. It is probable that the management of a self-insurance fund by a community hospital council would tend to promote elimination of malpractice, for through such a council information could be directly exchanged concerning the causes and problems involved in claims, with the consequent understanding of the actual causes of malpractice.

3. Since hospitals are community enterprises, the element of good will plays an important role when claims arise. If claims are handled with consideration for the injured party and reasonably settled, the hospital will improve its status as a service agency in the community.

4. Where the loss ratio to insurance cost over a period of years has proved to be low, it might prove economical to attempt group self-insurance, assuming that there is not likely to be any marked changes in the loss ratio in the future.

5. The many hospitals of a large metropolitan community tend to approach, if not exceed in variety, the risks assumed by those insurance companies writing a small volume scattered throughout the country. Out of a total of over twenty companies writing hospital mal-

practice insurance, only three have a premium volume over \$50,000, and a number of companies have only four or five malpractice contracts.

6. The self-insurance scheme as applied to one community would have an advantage over the private insurance company writing a limited volume in that legal decisions and opinions would tend to be approximately uniform within the community's jurisdiction, whereas the private insurance company, writing in various sections of the United States, must be prepared to interpret and defend claims having often fundamentally different legal bases, such as are shown to exist in the later chapter dealing with the analysis of legal liability. While the rates will presumably vary in direct relation to the factor of legal liability, in the cases of small companies they do not, for these companies lack the experience gained from writing a large number of risks, and they are unable to extend their experience because in this highly competitive line reciprocity among the companies is limited.

7. At the present time the cost of selling insurance and the administrative expenses are such a large percentage of the insurance premium that if the hospitals combined to operate their own insurance fund, it is possible that the total annual payments would be sufficient to meet losses and still result in a saving.¹

DISADVANTAGES

1. The group self-insurance fund may not be large enough to pay for the losses arising in cases of extremely large claims.

2. There are certain inherent difficulties in establishing and administering

¹ No figures for hospital malpractice insurance acquisition costs are available, but, assuming that they are comparable with those for general liability insurance, they would be approximately 40 per cent of the premium.

such a fund, the most important being the rivalry among hospitals in the same community and the general unwillingness to discuss and disclose malpractice claims. Another difficulty would be the problem of investing the funds of the self-insurance scheme.

3. A community group hospital self-insurance fund has only a limited opportunity for selecting risks and none for spreading liability over a large territory.

4. The legal and claim services obtained locally may not be so expert as those rendered by a private company.

5. Self-insurance limited exclusively to hospital malpractice would not be practical in those cases where the ratio of losses to payments is large. The private companies are willing to absorb those losses when they receive the contracts for the other forms of liability which the hospital must insure.

There are several methods of establishing a self-insurance fund. These may be outlined briefly. One is to have hospitals either pay or appropriate each year an amount equal to the premiums charged by private insurance companies until sufficient experience is acquired to adjust the rate in relation to losses and expenses. Another method, essentially related to the first, is to study the losses during the past few years and to attempt to establish an equitable basis, making charges proportionate to the past losses. A third system would be to acquire a permanent fund with sufficient interest earnings to meet annual losses. Such a system would remove the requirement of annual contributions, but hospitals do not have sufficient funds to establish an adequate permanent fund in a few years.

In the operation of a self-insurance fund it is imperative that the basic underwriting principles should not be sacrificed in the interests of disproportionate-

ly lower charges. Proper determination and distribution of risk among hospitals, the collection of adequate premiums, and the creation of reserves for normal losses, as well as a predetermined arrangement for extraordinary payments to meet unusual losses and the proper investment of the insurance fund are the criteria of an efficiently administered fund.

A word may be said about the need among hospitals in small cities and rural communities to carry their insurance, malpractice and other, in regular companies. In these places the number of risks are too few to establish a self-insurance scheme, and the proportionate effect of a single loss would work a great hardship.

Numerous advantages can be claimed for the enlistment of the professional risk-bearer, more commonly called the insurance company. By assuming a large number of risks, the insurance company can distribute the uneven and uncertain costs of many individual losses in a more equitable manner. Through the payment of a definite premium all insured hospitals are able to share one another's losses, within specified limits, as well as the cost of providing legal defense services. The removal of the uncertainty of loss enables hospitals to estimate and control financial outlays along definitely prescribed lines and thus to operate more efficiently.

Legal defense is one of the most important single services which hospitals derive from transferring malpractice risk to the insurance company. The benefits resulting from legal defense will be discussed more fully later, but mention can be made of the fact that many claims can be discouraged or thwarted, and certainly opposed much more adequately, if legal advice and counsel are obtained im-

mediately when claims are presented. Delay in calling competent legal experts tends to weaken the hospital's defense and definitely increases costs. Another element which makes the legal defense provided by insurance companies so important is the fact that, through extensive data collected by their legal departments, they are acquainted with the intricate problems which arise in the various jurisdictions. Through the large

number of malpractice claims which some of them handle, they have an advantage over independent attorneys who devote only a part of their time and efforts to such specialized problems.

The interests of the hospital and the insurance company are the same in that they attempt to provide adequate legal defense and in that they thoroughly investigate every claim to determine whether or not it is justified.

CHAPTER IV

THE INSURANCE APPLICATION AND CONTRACT

THE first formal step which a hospital takes in obtaining protection from an insurance company is to submit an application for hospital malpractice insurance. This may be done directly by the hospital, but it is a function commonly performed by a local insurance broker. The submission of an application does not put any insurance contract into force. It is merely an indication that the hospital wishes to negotiate a contract with the company which it is addressing.

Owing to the extreme variation among hospitals treating even the same types of patients and to the exceedingly hazardous risks which hospitals may present, the application forms of many companies are quite detailed in order to give a fairly complete picture of hospital operations and to afford a basis for computing the premium to be charged. The information requested is of value to the insurance company in deciding, primarily, whether or not it will accept the hospital as a justifiable risk. Some of the data customarily required by the company may be described with attention being given to the specific use or import of the information. A sample application is given in Appendix A.¹

That the name and address of the assured should be stated correctly is obvious. If there are any persons who have an insurable interest² in the hospital,

their names should be included jointly with the hospital's name.

The question concerning whether the hospital is maintained in whole or in part by public or private funds or endowment is important to the insurance company, since it affects the hospital's legal status as to liability. A hospital receiving public or private funds has an advantage in legal defense over one that does not, for it can claim that these funds may not be used for the payment of judgments for torts.³

Whether or not the hospital is operated for profit is a fundamental consideration, and a distinction should be made between a hospital which may operate with a periodic surplus and one operated for profit. The distinguishing feature is that a hospital operated for profit implies that someone is legally entitled to withdraw earnings, whereas one which may operate at a surplus cannot dispose of its excess funds but must reinvest them in the plant and/or apply them to the operation of the hospital. The importance of the distinction "operated for profit" arises from the fact that such hospitals are generally conceded to be as fully liable under the law as private enterprise and, all other factors being equal, tend to bear a higher risk and therefore a higher premium rate than nonprofit hospitals.

The problem of the percentage of char-injury of some kind to the insured" (E. W. Patterson, *Essentials of Insurance Law* [New York: McGraw-Hill Book Co., 1935], p. 87).

³ J. A. Lapp and D. Ketcham, *Hospital Law* (Milwaukee: Bruce Publishing Co., 1926), pp. 96-97.

¹ Derived from the application of a company writing a large volume of hospital malpractice insurance.

² "An insurable interest is a relation between the insured and the event insured against such that the occurrence of the event will cause substantial loss or

ity patients customarily treated is also significant as a measure of liability from the legal standpoint. Twenty or more years ago hospitals did a much greater amount of charity work than they do today. But with the continued increasing proportion of pay and part-pay patients, the courts have in some instances rebelled against designating hospitals as charities when the major portion of their income was derived from patient charges. While this factor may not have changed the legal status of the hospital as a charity, it has prejudiced its position in respect to liability and is therefore important to any insurance company which may carry the hospital's malpractice risk.

The stamp of approval of the American College of Surgeons and the date of approval are highly informative, for approved hospitals may be presumed to be better risks. An estimate of the degree to which they are better risks will be given in the chapter dealing with claims.

An inquiry concerning any claims or suits for alleged malpractice, pending or closed, against the applicant is essential, since hospitals with claims are likely to be bad risks. They can be accepted only after a careful examination to determine what elements in the hospital's internal organization and administration are contributing toward claims. Even after these are eliminated, there remains the necessity of anticipating new claims which may arise from publicity incident to past claims. The purpose of determining whether any company has canceled or declined to issue hospital malpractice insurance is obviously intended to supply the company with the experience of others.

The classes of patients treated in the hospital influence the amount of risk. Their comparative importance was dis-

cussed in an earlier chapter dealing with considerations influencing malpractice risk.

The names of members of the hospital staff and the specialties which some of them pursue are important in a number of respects. Some insurance companies include a charge in the computation of the premium for every physician and surgeon. If the companies are writing professional malpractice insurance for any of these physicians, the company files can be studied for the claim records of these men. If there are a few who have had a number of serious claims brought against them personally, they may increase the amount of risk present in the hospital when the doctor may be accused of some act of malpractice and the hospital named in joint suit. In the actual counting of staff doctors, the question arises of whether courtesy staff should be included. Some companies do not indicate how inclusive the term "staff" is intended to be.

The recent and continued growth in the number of clinics and the quantity of care given in them has a bearing on the amount of risk. While no direct charge may be made for the clinic when coverage is provided, the charity status of the clinic and its legal position in relation to the hospital should be considered when writing the hospital, as well as the adequacy of the professional medical and nursing staff to render service of a high character.

The reporting of the number of professional and technical personnel employed by the hospital serves a twofold purpose. It indicates to the company how fully the hospital is meeting the patient-load requirements and also serves as a partial basis for determining the premium to be paid. It is interesting to note in the application form presented in Appendix A

the division of nurses, both graduate and student, employed during the day and the night. Since many accidents occur at night, the company can determine from the reported data whether a skeleton nursing staff is employed at night and whether the greater part of the responsibility for nursing service at that time falls on the shoulders of graduates or students. The term "practical" nurses, which is used in the same application form, is likely to refer to ward helpers or similar nurse auxiliary employees, since hospitals do not employ "practical" nurses, as the term is commonly used.

The number of beds devoted to full-pay or part-pay patients in contrast to beds devoted to charity patients is significant, since it serves for many companies as the basis of determining premiums. Insurance companies go on the assumption that, the larger the percentage of charity cases, the less chance there is of the courts' holding the hospital liable as a possible proprietary institution. These companies define the group of charity hospitals as those "not operated for profit and/or having 25 per cent or more charity cases" and define proprietary hospitals as those "operated for profit and/or having less than 25 per cent charity cases."⁴ Since there may be a difference of over 100 per cent in premiums between the two groups, the importance in careful determination of the bed classification in a particular hospital is evident.

The application also calls for the average bed occupancy during the past year. Some companies have found that to charge certain hospitals for every bed, whether occupied or not, was not equitable. They have therefore evolved two methods of computing the premium, one

based on rated bed capacity, the other on average occupancy.

The questions concerning X-ray and radium are important to insurance companies, for they feel that this treatment is particularly hazardous. There is usually a charge for X-ray, often very high, as will be seen later. Radium is considered to be so hazardous by most companies that they request a waiver excluding it from the contract unless they are satisfied that the physician in charge is competent to give treatment, and then they will provide this coverage only at an addition in the premium.

It should be obvious to anyone considering the purchase of hospital malpractice insurance that misrepresentation cannot be condoned by the company and automatically renders the contract null and void. The statement regarding false swearing, as given by one company, may well be repeated here:

This entire policy shall be void if the Assured has concealed or misrepresented any material fact or circumstances concerning this insurance or the subject thereof, or in case of any fraud, attempted fraud, or false swearing by the Assured, touching any matter relating to this insurance or the subject thereof, whether before or after a loss.⁵

When this information is sent to the company, it is carefully scrutinized to determine whether the particular hospital is a desirable risk. In addition, some companies which employ private practitioners or company physicians in the community in which the hospital is located frequently call upon them for a confidential report of their opinion concerning the character of the hospital management and the quality of care rendered. This source is particularly valuable as a guide regarding the moral hazard of the hospital, as well as providing

⁴ From rate manual of insurance company.

⁵ See contract in Appen. B.

information which hospital authorities may not be called upon to disclose.

Because of the difficult problems which must be faced in studying the intricacies of a particular hospital organization, judgment as to the acceptability of any hospital risk is customarily passed in the home office, where all contracts are made.

The parties to the hospital malpractice insurance contract are subject to the same rules of law as any two contracting parties, in addition to some which are characteristic of insurance contracts. These, briefly stated, are:

- a) The contract must be made between two parties legally capable of making a contract.
- b) There must be a mutual meeting of the minds—that is, both parties must understand the same thing about the subject matter under discussion.
- c) There must be a consideration. In insurance contracts this consideration is called the "premium."⁶

Those applying particularly to insurance contracts are:

- a) There must be an insurable interest on the part of the policyholder. Insurance is not gambling, and a policy made out to an individual or corporation that did not have an insurable interest in the subject matter of the insurance would be contrary to public policy, and would not be valid, since there would be no risk of loss on the part of the policyholder.
- b) To collect under an insurance contract a loss must be suffered by the policyholder.⁷

In purchasing hospital malpractice insurance, it is important that hospital authorities give attention to the amount of coverage provided by the contracts of different companies. The contract should be read carefully and examined by an attorney of the hospital. For, as will be

shown, the contracts of different companies are not identical, and it is quite possible that a cheap policy, that is, one for which a low premium is charged, may not offer the extent of coverage which the hospital desires or expects to receive.

Simplicity is essential in any insurance contract. A contract replete with particular restrictions may raise questions of interpretation regarding the extent of coverage really provided. The insurance policy should be intelligible to a person not particularly conversant with insurance or legal matters.

Hospital malpractice insurance is more or less standardized. Certain clauses are found in practically all policies, varying somewhat in phraseology but not materially in meaning. Others are not identical and on comparison show definite variations in the degree of coverage provided. These are the more important and will be examined carefully.

As will be seen from the sample contract presented in Appendix B, the policy is arranged in the following order: the statement concerning what the company agrees to do toward the payment of damages, the provision and payment of defense, the definition of rights regarding the settlement of claims, the limits of liability for damages, the particular exclusions from liability which are agreed to, and, finally, a series of clauses defining the conditions under which the policy shall be considered to be in force. The arrangement and grouping of these clauses are not identical in different contracts.

Instead of examining the comprehensible provisions of the sample contract, a critical survey will be made of eight contracts in order to locate and explain the differences in the provisions for coverage which each provides (see Table 4). Space does not permit the inclusion of these

⁶ Rexford Crewe, "The Insurance Transaction," in G. F. Michelbacher, *Casualty Insurance Principles* (New York: McGraw-Hill Book Co., 1930), p. 160.

⁷ *Ibid.*

contracts individually, nor, for ethical reasons, are the names of the companies disclosed. However, the reasons why some types of clauses are preferable to others will be presented, for the content of certain clauses has a vital relation to the coverage provided by the contract.

age to claims arising from "bodily injuries or death." One authority has expressed the opinion that "some claims may be outlawed by such phraseology" and that it is a "survival of policies of a decade ago, which might have been adequate in their day but not since the pub-

TABLE 4

COMPARISON OF SELECTED ELEMENTS OF COVERAGE PROVIDED BY EIGHT REPRESENTATIVE HOSPITAL MALPRACTICE INSURANCE CONTRACTS

PROVISIONS OF COVERAGE	COMPANY							
	A	B	C	D	E	F	G	H
Injury to patient limited to "bodily injuries or death"	No	Yes	Yes	Yes	Yes	No	Yes	Yes
Coverage provided in out-patient department	Yes	Yes	*	Yes	Yes	*	Yes	No
Coverage provided in ambulance	Yes	*	Yes	Yes	Yes	*	Yes	*
Coverage provided for autopsies	Yes	*	No	Yes	*	Yes	*	*
Include clause that company is not liable for damages caused by person giving treatment while under influence of intoxicants or drugs, or performing an unlawful act	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Full or partial payment by company of all claim investigation and defense expenses	Yes	Yes	*	Yes	Yes	Yes	Yes	*
Right to settle or compromise claim determined by hospital	Yes	Yes	*	No	Yes	Yes	Yes	Yes
Company reserves right to cancel policy during premium year with return of part of premium	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
First limit of indemnity:								
"Any one injured person"	.....	Yes	Yes	Yes	Yes	.....	.....	.....
"Any one claim or suit"	Yes	.....	.....	.....	.....	Yes	Yes	Yes
Second limit of indemnity:								
Total of all claims paid in one policy year (not permanent limit)	Yes	No	No	Yes	No	Yes	Yes	Yes

* No mention made in the contract of this aspect of coverage.

By far the most important part of the contract is the insuring clause, since it controls all subsequent contract provisions. Insuring clauses are so drawn as to meet either all or certain kinds of claims for damages imposed by law upon the insured.

The contract presented in Appendix B is as inclusive as any can possibly be, that is, it insures against all claims. Some are more restricted, limiting cover-

lic and its lawyers became expert in modern litigation against the professions."⁸

There are some policies which modify the "bodily injury or death" phrase by insuring the hospital for damages on account of "bodily injuries (including shock, mental anguish, and personal restraint) and/or death suffered, or alleged to have been suffered." Policies with

⁸ Harry A. Prevost, "How Much Protection Does Liability Insurance Contract Provide?" *Hospital Management*, December, 1933, p. 43.

such clauses are more liberal than those restricted to "bodily injuries or death." However, under common law no recovery can be obtained for mental anguish or alleged harm not resulting in physical injury. This common-law rule does not bar claimants from threatening suit for mental anguish. If a hospital must go to court because of such allegations, it will be provided with legal protection by the insurance company under the above-modified bodily injury clause, and, even where the contract specifies coverage for "bodily injuries" only, it is doubtful whether the insurance company will permit the hospital to go to court without having the company's legal representative present.

Another phrase which is found in some insuring clauses is that the company insures the hospital for damages imposed by law, "including damages for care, maintenance, and loss of services."

Frequently there are two suits brought; one by the patient or in behalf of the patient for damages due to the alleged injury itself, the other by someone having a personal interest in the well-being of the patient, such as a husband, wife, parent or child and this suit is called "for loss of services," "loss of support," or sometimes "property damage" (strange as the last phrase may seem to the layman).⁹

The insertion of the above clause would give protection for such combined suits, but the question arises as to the indemnity limits provided by the policy. For example, if the policy has a first limit of \$5,000 and the patient obtains a verdict of \$5,000, and another person with an interest in the patient is awarded damages of \$2,000, giving a total of \$7,000 for both, will payment be made under the policy for the full amount or only \$5,000 for both?¹⁰

⁹ *Ibid.*, p. 44.

¹⁰ *Ibid.*

Another coverage problem of importance to many hospitals is whether provision is made for alleged acts of malpractice arising from care given in the outpatient department, clinic, or dispensary of the hospital. An examination of eight contracts shows specific coverage in five and no mention made in three. In the latter group, the question of whether or not coverage is provided may center upon whether the ambulatory care given patients is a function of a dependent department of the hospital or whether it is carried out by a legally independent organization which may or may not have professional and financial ties with the hospital.

Coverage for malpractice in ambulances is a problem somewhat related to the above. Five of the contracts provide this coverage, limiting it to those ambulances owned and operated or maintained by the hospital.

Some policies provide protection against claims arising out of autopsies; others fail to do so. Of those examined, three specifically mention protection and four do not, leaving one which definitely provides no coverage. Some of these policies can be interpreted to be in force only when the alleged injury occurred to a living patient.¹¹ The importance of having this protection in the contract should be evident to hospital authorities.

All the policies examined contained a waiver stating that the policy would not apply if the claim occurred because the person connected with the hospital was under the influence of intoxicants or narcotics or was performing an unlawful act. However, in regard to suits alleging criminal malpractice or the violation of the law, not all the policies stated specifically whether or not they would defend the hospital.

¹¹ *Ibid.*

In regard to the law of insurability against the commission of unlawful acts, no cases are known in the field of hospital malpractice insurance, but the reasoning applied in the field of auto liability insurance can be given as a guide.

At one time, it was contended that liability insurance was illegal because it tended to make the insured careless of the safety of others. The validity of such insurance has been universally upheld, however, though it covers liability for injuries caused by violations of traffic laws.¹² A person can lawfully insure against liability for the willful or even criminal acts of his employees, in which he does not participate.¹³ Probably, insurance against civil liability due to the operation of a motor car would not cover a case of willful murder by the insured; certainly, an agreement to pay the insured's criminal penalty or to indemnify him against loss of time while in prison would be illegal.¹⁴

The doctrine has long been current that when the facts affording a cause of action in tort are such as to amount to a felony, there is no civil remedy against the felon for the wrong, at all events before the crime has been prosecuted to conviction. And as, before 1870, a convicted felon's property was forfeited, there would at common law be no effectual remedy afterwards. So that the compendious form in which the rule is often stated, that "the trespass was merged in the felony," was substantially if not technically correct. But much doubt has been raised in the matter in several modern cases, and for a long time it was hard to say either exactly what the rule was or how it should be applied in practice. Still it is the law that where the same facts amount to a felony and are such as in themselves would constitute a civil wrong, a cause for action for the civil wrong does indeed arise, but the remedy is not available for a person who might have prosecuted the wrong-doer for the felony, and has failed to do so. The plaintiff ought to show that the felon has actually been prosecuted to conviction (by whom it does not matter, nor whether for the same general of-

fense), or that prosecution is impossible (as by the death of the felon or his immediate escape beyond the jurisdiction), or that he has endeavoured to bring the offender to justice, and has failed without any fault of his own.

While, however, the law was commonly so stated, it was nowhere laid down how practical effect was to be given to it. The objection was not a ground of demurrer, could not be pleaded, and would not warrant nonsuit if the facts showing a felony came out in evidence. The Court of Appeal finally decided, in accordance with the suggestion made by Blackburn J. in 1872, that the proper course is for the Court to stay proceedings (which may be done on interlocutory application) until the defendant has been prosecuted. Discussion of the earlier authorities is therefore no longer useful.¹⁵

Mr. Prevost, in addressing hospital authorities, has said:

All policies must contain provisions and agreements defining and limiting the action of both parties to the contract. . . . [Hospital executives] should make sure that those relating to the assured are reasonable and definite and that the insurance company does not assign to itself any rights which may be unfair to the interests of the hospital. If the policy provides that compromise settlements may be effected rather than trial through the courts, which party, the hospital or the insurance company, holds the right of decision?¹⁶

Of the eight contracts studied, six stipulate that the hospital holds the right to decide whether or not to compromise. One insurance company indicated that it specifically retained the right, and one did not make any provision. The question arises where the policy does not include the right of compromise of how the contract is to be interpreted in case the hospital's authorities consider it to their interest to avoid public litigation. On the one hand, hospitals do not desire the publicity resulting when claims go to court, whereas the insurance companies,

¹² *Messersmith v. American Fidelity Co.*, 232 N. Y. 161, 133 N.E. 432 (1921).

¹³ *Taxicab Motor Co. v. Pacific Coast Casualty Co.*, 73 Wash. 631, 639, 132 Pac. 393 (1913); *Robinson v. U.S. Fidelity Co.*, 131 So. 541 (Miss., 1931).

¹⁴ *Patterson, op. cit.*, pp. 48-49.

¹⁵ Frederick Pollock, *The Law of Torts* (13th ed.; London: Stevens & Sons, Ltd., 1929), pp. 205-7.

¹⁶ *Op. cit.*, p. 44.

in many cases of exaggerated claims, cannot defend themselves unless they go to court. As a practical measure, if an insurance company wishes to go to court and the hospital prefers to compromise, the company can insist upon defense under any of the contracts studied, "but it handicaps its own position in forcing a reluctant patron into court and as a matter of practical procedure rarely can insist upon its technical policy rights beyond a certain point."¹⁷

Regarding the cancellation privileges, all the policies studied provided that they may be canceled during the premium year with a return of part of the premium for the unexpired term computed and adjusted either pro rata or according to short rates as given in a table adjoined to the contract. Prevost reports, however, that there are some policies which

cannot be cancelled either by the insurance company or by the insured hospital during the annual term for which the policy has been approved by the company and the premium paid by the insured. Some permit cancellation by the company with return of the premium for the unexpired term, but the hospital does not enjoy this right. Finally, some policies contain the right of cancellation by either party to the contract, subject to premium adjustment.¹⁸

This was found to be the case in the eight policies examined.

In actual practice it is seldom that a company, having once accepted an application based on a true and full statement of the facts necessary for underwriting and premium rating purposes, cancels for any cause during the premium term. If the claim experience indicates that continuation of the insurance will be at constant and repeated losses, the company usually contents itself with refusing to renew the policy.¹⁹

¹⁷ *Ibid.*

¹⁸ *Ibid.*, pp. 44 and 46.

¹⁹ *Ibid.*, p. 46.

The majority of the policies studied have two limits of liability which are the maximum amounts payable for damages. The first limit is customarily \$5,000; the second, \$15,000. It is important to distinguish whether the first limit as applied in the contract is for "any one injured person" or for "any one claim or suit," since the latter provides a broader inclusion which would provide coverage if the patient brought suit for damages jointly with someone who had an interest in his well-being, with the total damages exceeding \$5,000, but neither one doing so.²⁰ Out of the eight policies, only four described the limit by the more desirable phrase, "any one claim or suit."

With regard to the second limit,

the policy should state that this second limit includes the total of all claims paid in any policy year. If it does not, it may be considered as a "permanent" limit and applicable to the full life of the policy, no matter how many years it may be renewed. Its value is, accordingly, much diminished.²¹

While it is true that few hospitals become involved in so many damage suits that the second limit is reached, the possibility exists, and the hospital should expect to be protected against such a contingency.²²

Briefly reviewing the data regarding the extent of coverage provided, it is evident that there is no complete uniformity among the contracts studied. A hospital, therefore, when buying this insurance, should study the contract carefully, for it has been demonstrated that, contrary to popular opinion, the contracts for this type of insurance are sufficiently varied to make it imperative that they be considered jointly with the factors of rates and service in selecting the company

²⁰ *Ibid.*, p. 44.

²¹ *Ibid.*

²² *Ibid.*

with which the hospital will buy insurance.

At the present time a new hospital insurance contract, known as a master-contract, is being introduced to the hospital field. This master-contract covers all forms of insurance commonly needed by hospitals. In the preparation of the contract, the officers of the American College of Surgeons and the Modern Hospital Publishing Company were consulted in an endeavor to meet the peculiar requirements of the hospital field. A specimen copy of this contract is reproduced in Appendix B.

In view of the possible controversy which may be raised by this contract, it may be well to comment constructively on the advantages and disadvantages of this new insurance and the plan under which it is to be offered. First, the master-contract is written with the intention of giving complete protection to the hospital against all liability hazards except those arising from watercraft, aircraft, automotive equipment, and workmen's compensation. Second, it is claimed that this new contract will be sold at premiums at least 25 per cent lower than those of other companies. Third, only hospitals approved by the American College of Surgeons will be permitted to purchase this insurance. This means that the new contract will be sold only to those hospitals which occupy a preferential risk position. Fourth, the organization which is underwriting this insurance, namely, Lloyds of London, promises to disclose fully its experience with this form of insurance and to make it available to the hospital field through the agency of the American College of Surgeons. This will give a basis for the critical evaluation of rates and also serve to introduce a statistical basis for the intelligent elimination of hazards. Fifth, in

addition to insuring the hospital, the new contract also provides coverage at nominal rates to hospital staff physicians. This protection extends beyond the realm of the hospital and into private medical practice, thus removing the need on the part of the physician to purchase individual malpractice insurance. This insurance of hospital staff physicians is accomplished by means of individual, numbered certificates of insurance which provide the physicians with the same coverage the hospital receives under the same limits of liability. Sixth, it is expected that the saving in the selling expense of one master-contract rather than two to eight individual contracts will contribute materially to lower rates. Similarly, all doctors on the staff desiring insurance against legal liability will purchase it at the same time under the same flat rate. Finally, this type of insurance under a master-contract has been written with success for the last seven years in analogous lines, an outstanding example being druggists' liability, particularly as applied to chain drugstores.

It would be a mistake to assume that this form of insurance had no faults or shortcomings. The disadvantages which exist or may arise are serious and deserve consideration. First, Lloyds refuses to insure, at any price, hospitals not approved by the American College of Surgeons. While it may be claimed that this is intended indirectly to persuade hospitals to seek approval, it must be admitted that conditions beyond local control make it impossible in many cases for these hospitals to obtain approval. The refusal to insure nonapproved hospitals at any premium may work a serious hardship upon hospitals which because of extraneous reasons cannot afford to meet the requirements of the College. Second, no claim and adjustment service

through branch offices of the company will be available, as is the case with American companies. Under Lloyds' contracts all claim investigations and adjustments are handled through a designated legal firm with offices and associates in the major cities of the United States. Third, if all doctors are to be insured at the same rate, the plan is contrary to the logical classification of risks. Radiologists and certain other specialists work under more hazardous conditions, and claims against them are more serious and extensive. Finally, the most serious objection of all is that Lloyds of London is an alien company. As such, it is subject to certain restrictions which in turn affect the hospitals which may insure with it. As a foreign organization, Lloyds of London makes no financial re-

port to any American governmental insurance department, either federal or state, nor is it subject to their supervision or control. The following opinion was offered by Louis H. Pink, superintendent of insurance of the state of New York:

Lloyds has no status whatever in this state and has been recognized only in Illinois, where the Insurance Code now awaiting the Governor's signature will undoubtedly curtail the operations of those now recognized. The courts of this state cannot take jurisdiction over London Lloyds and the protection of the courts as well as of the Insurance Department is not available to anyone purchasing such insurance. Their business can only be transacted through correspondence and no one may legally aid them in the transaction of business within the borders of this state, and in fact, most of the states.²³

²³ Letter, June 7, 1937.

CHAPTER V

RATES AND RATE-MAKING

RATES are nothing more than the prices charged for insurance. It is expected that they will be set at that point where the company can pay costs and receive a reasonable profit.

The rate can be divided into two parts, namely, the pure premium and the expense loading.¹ The pure premium represents the expected losses, the claim expenses which can be directly attached to specific, individual claims and the reserve which must be set up against losses which are deferred. The expense loading, on the other hand, is the amount of expected general expenses in writing the insurance and the underwriting profit.

Its function is to provide the carrier with a fund sufficient to cover the necessary expenses incidental to the insurance transaction, such as the cost of production (agent's commissions), taxes, maintenance of home office and field organization, inspections, etc., and to allow a reasonable underwriting profit.²

The methods employed in computing rates for different kinds of insurance are dependent on the character and quantity of data available which have been derived from the experience that one or more companies have had in writing this particular kind of insurance. For example, life insurance rates are based, in large part, on mortality tables which show what past experience has been. By examining these data, a competent actuary can compute and determine by

mathematically accurate means what future experience will probably be. In this case rates can be measured with remarkable accuracy for comparatively long periods of time.

In the case of workmen's compensation insurance and certain other types of insurance there is a complicating factor in the computing of rates in that new elements, such as the reduction of machine hazards through the use of safeguards, may arise in the future. When considered from the long-time-trend point of view, these elements do not repeat themselves with as little variation as do the factors of life insurance. Therefore, measurements affecting rates are usually short run. In this field a method of experience rating has been devised by Mr. Albert W. Whitney, of the National Bureau of Casualty and Surety Underwriters.³ With the application of a definite formula, rates can be set with a reasonable degree of accuracy.

Rates for hospital malpractice insurance are based on two general factors, namely, underwriting judgment regarding what rates should be and the interpretive analysis of statistical data. As the volume of business grows, companies are more and more able to base rates on definite, quantitative information and to measure whether past rates have been adequate to meet claims, including those which have been deferred.

Unfortunately, at the present time,

¹ G. F. Michelbacher, *Casualty Insurance Principles* (New York: McGraw-Hill Book Co., 1930), p. 187.

² *Ibid.*

³ "The Theory of Experience Rating," *Proceedings of the Casualty Actuarial and Statistical Society of America*, IV, No. 10 (1918), 274.

there are only a very few companies writing a sufficient volume of hospital malpractice insurance to determine rates in a logical and scientific manner. All others must look to these large writers for guidance in setting rates, although it is quite probable that there may be a wide variation between the risks written by a company with a large volume and one writing a small volume. Another point to be borne in mind is that the proportionate influence of a bad risk accepted by a company is much greater if accepted for insurance by one writing a small volume than it would be in another.

The problem for the small underwriter is complicated by the fact that rates cannot be set equitably for the nation as a whole but must be varied upward and downward from the base rate to allow for the variations in liability of hospitals in different states and also for other factors. Some illustrations of the extent of this variable will be shown in the chapter dealing with claims.

Finally, there is the element of deferred claims. A statistical analysis of deferment will be given in the next chapter, but it may be pointed out that claims may and do arise within the statutes of limitations which vary up to seven years in some states and that these claims must be defended by the insurance company writing the hospital during the year that the alleged malpractice occurred. Again, such deferred claims may have a proportionately more important influence on a company writing a small volume.

The importance of this factor in determining rates may be indicated by the testimony of an insurance executive whose company writes this line.

One of the most important problems which the underwriter of this class of risk must have in mind is the fact that ultimate loss experience

matures very slowly because of the long deferred liability. In other words, we may be called upon today to defend claims and settle losses arising from alleged malpractice occurring several years ago.

If this type of loss could be determined at the end of the policy year, or shortly thereafter, the problem of establishing adequate rates would be greatly simplified. However, the fact that the insurance contract provides both defense and indemnity for claims or suits whenever arising and due to alleged occurrences during the policy year makes the calculation of adequate rates a difficult problem.⁴

Granted that hospital malpractice insurance rates are determined by judgment plus analysis of experience, provided that the latter is available in sufficient volume to permit a fairly complete scrutiny yielding significant results, it will be interesting and also important to examine the rates which are actually charged. This can be done in one of two ways: either by taking the base rates given by the insurance companies or by studying the rates which companies actually charge in a selected state as reported by the companies to the particular state's insurance department.

The latter course has been followed, and New York State has been selected for a number of important reasons. First of these is the fact that the companies' base rates are not necessarily the actual rates charged, because the companies have found that conditions affecting the writing of this line vary among the different states, and therefore they alter their rates to correspond as nearly as possible with these factors. The second fact that influenced the selection is that New York State has one of the finest insurance departments in the country. Third, the law affecting the liability of hospitals has reached a comparatively stable level in New York State, and there are avail-

⁴ Letter, November 18, 1936.

able case interpretations by the courts which are well reasoned.⁵ Finally, New York State can be divided for rate analysis purposes into two contrasting areas, namely, metropolitan New York City and upstate New York.

The rates which were charged for hospital malpractice insurance on December 1, 1936, for some of the companies writing in New York State are given in Tables 5-10. For purposes of comparison some of the rates as reported to the state insurance department have been itemized more or less fully in order to bring them within the arrangement of the table and to facilitate comparisons, but their meaning or content has not been changed in any way.

Of the companies writing in the state, eleven have fairly comparable bases for charges, and these have been combined into Table 5. It will be seen that the companies employ some or all of the following bases in computing charges: bed charge, professional staff charge, pharmacist charge, X-ray charge, and ambulance charge. It may be profitable to examine the nature of some of these charges and look at the reasoning involved in support of each. All eleven companies in Table 5 have a bed, bassinet, or bed and bassinet charge. Quite obviously, the more beds which a hospital uses, the greater the amount of risk. But there is confusion in the minds of the executives of some companies, for among the companies listed there are some which base charges on the total number of beds in the hospital and not on the occupied beds as represented by average occupancy. Clearly, empty beds do not present a malpractice hazard, except in so far as

they may be occupied during the policy year.

Three of the eleven companies in Table 5 have a differential bed rating for hospitals, charging \$2.00 per bed for hospitals having over 50 beds and \$3.00 for those with under 50. There is some question whether the dividing-line of 50 beds is such as to represent a change in risk sufficient to warrant a 50 per cent increase in bed charge for hospitals with under 50 beds. However, the question can only be raised, for data are lacking to determine whether the particular point of 50 beds is justified as the best point at which to make the change and whether the differential charge is properly apportioned.

In this table only one of the companies has indicated the variations in bed charges according to whether the beds are for charitable, semicharitable, or private purposes. For the charitable beds the bed charge is \$2.00 in hospitals with more than 50 beds, and \$3.00 for those under. Then, regardless of the size of the hospital, the bed charge increases to \$8.50 for each semicharitable bed and \$16.00 for each private bed. The abrupt and large variations in charges are interesting as a reflection, not of increased risk due to changes in the quality of hospital care, but of the increased legal liability which attaches to the rendering of care in proprietary hospitals. The questions of what is a charity bed, what is a private bed, and whether hospitals are less liable for negligence arising from the care of free patients as contrasted with pay patients will be reserved for later discussion.

The second basis for computing the premium is the professional staff charge. Ten of the eleven companies being discussed include this charge, but the classes of physicians and surgeons included

⁵ John A. Appleman, "The Tort Liability of Charitable Institutions," *American Bar Association Journal*, January, 1936, p. 51.

HOSPITAL MALPRACTICE INSURANCE

TABLE 5*

HOSPITAL MALPRACTICE INSURANCE RATES FOR ELEVEN COMPANIES WRITING
IN NEW YORK STATE AS OF DECEMBER 1, 1936

BASIS OF CHARGE	COMPANY										
	A	B†	C	D	E	F†	G†	H†	I	J	K†
<i>Bed charge (each):</i>											
Beds.....			\$ 3.00			\$ 1.50		\$ 1.50	\$0.70	\$1.50†	\$ 1.50
Bassinets.....	\$1.00										
Beds and bassinets.....		\$ 1.50		\$ 1.50							
1-50 beds.....	3.00				\$ 3.00		\$ 3.00				
Over 50 beds.....	2.00				2.00		2.00				
Semicharitable beds.....							8.50				
Private beds.....							16.00				
<i>Professional staff charge (each):</i>											
Physicians and surgeons.....		5.00	10.00	10.00§	15.00¶		5.00	5.00		5.00	5.00
Physicians and surgeons attached to hospital staff.....							10.00				
Physicians, surgeons, and dentists in out-patient department.....					10.00	5.00					
<i>Pharmacist charge (each):</i>											
Pharmacist.....		5.00	5.00					5.00			
<i>X-ray charge (each):</i>											
X-ray operators.....		5.00						5.00	6.50		
X-ray operators—diagnosis.....			10.00								
X-ray operators—treatment.....			25.00								
<i>Ambulance charge (each):</i>											
Ambulance.....							10.00				
Ambulance drivers.....		5.00			10.00			5.00			
<i>Minimum premium.</i>		50.00		230.00	100.00	100.00		50.00			50.00

* Source: New York State Insurance Department rate file.

† Rates for charity hospitals only.

‡ Rates based on average occupancy.

§ Includes "professors directing students" and "Senior A students."

¶ Includes practicing physicians, surgeons, and individuals or members of copartnership operating hospitals.

vary. In Table 5 six companies charge either \$5.00 or \$10.00 for every physician and surgeon. One of the companies charging \$5.00 for this group refines its charge by increasing the amount to \$10.00 for all physicians and surgeons attached to the hospital staff, reserving the \$5.00 charge for courtesy staff. Two of the companies do not make any charge for hospital physicians and surgeons but charge only for physicians, surgeons, and dentists employed in the out-patient department. One company charges for professors directing students and for senior students. Finally, another company has a \$15.00 charge for practicing physicians, surgeons, and individuals or members of a copartnership operating a hospital.

The many variations in this phase of rate structure present problems which hospital authorities should examine carefully when purchasing insurance. Whether the company includes the courtesy staff in its charge will have an important bearing on the total amount of the premium. How the company deals with interns, whether licensed or not, will be significant. All the variations in the amount and inclusiveness of the professional staff charges are matters which concern hospital authorities who pay the bill and, to some extent, reflect the insight of the insurance company into hospital organization. If the professional staff charges contain elements or factors which betray the fact that particular insurance companies are ignorant of professional staff relationships within hospitals, the administrators of hospitals will detect this and justifiably suspect that the insurance company is not intimately conversant with hospital organization and that they do not employ personnel familiar with the hospital field. The question arises whether the doctor is an agent of the hospital or an inde-

pendent agent. This matter is decided differently by the courts in different jurisdictions. Generally, it has been held that private practitioners using the hospitals for the treatment of patients are independent agents who have been approved by hospital boards of trustees as meeting the standards of medical care obtaining in the particular hospitals.⁶ Interns and doctors paid by the hospitals are considered to be employees of the hospital. If an act of malpractice is committed by a doctor who is a private agent, the patient can sue the doctor and, if no hospital employee is involved, can recover only from the doctor, even though the hospital is joined in suit with the doctor. Therefore the charge for physicians and surgeons is logically unnecessary in practically all jurisdictions.

The third basis of charge is that for the pharmacists employed by the hospital. Only three of the eleven companies have a \$5.00 charge for every pharmacist. Here again there would be justification for the argument that the hospital paying a \$5.00 fee for every pharmacist was being penalized for decreasing the malpractice risk.

The fourth basis for charge is X-ray, and the charge is computed on either the number of operators or the number of machines. Five of the eleven companies make this charge, two charging \$5.00 for every operator, and one \$6.50. One company cited in the table differentiates between X-ray operators who do diagnosis and those who give therapeutic treatments, charging \$10.00 for the former and \$25.00 for the other. The one company which bases its charge on the number of X-ray machines may be working some injustice upon hospitals, not simply

⁶ J. A. Lapp and D. Ketcham, *Hospital Law* (Milwaukee: Bruce Publishing Co., 1926), pp. 115-20.

because the charge for each machine is \$25.00, but because it is not a satisfactory basis. Very often hospitals having an extensive X-ray service may have machines which are used quite infrequently or which have been replaced by new

TABLE 6*

HOSPITAL MALPRACTICE INSURANCE RATES FOR
COMPANY L, WRITING IN NEW YORK STATE
AS OF DECEMBER 1, 1936

Basis of Charge	Greater New York	Else- where in New York
<i>Bed charge (each):</i>		
Charity hospitals.....	\$ 3.00	\$ 2.00
All others.....	16.00	12.00
<i>Professional staff charge (each):</i>		
Resident charge—graduate licensed physician, surgeon, or dentist, graduate or undergraduate intern or extern employed by hospital.....	10.00	10.00
<i>Pharmacist charge (each):</i>		
Pharmacist.....	5.00	5.00
<i>X-ray charge (each):</i>		
X-ray operators—treatment....	5.00	5.00
X-ray machines—treatment....	25.00	25.00
Radium charge—if used and property of hospital.....	50.00	50.00
<i>Ambulance charge (each):</i>		
Ambulance drivers.....	5.00	5.00
<i>Laboratory charge (each):</i>		
Laboratory technicians.....	5.00	5.00
<i>Minimum premium.....</i>	50.00	100.00

* Source: New York State Insurance Department rate file.

equipment but are kept on hand as a reserve to handle peak loads.

The ambulance or ambulance-driver charge is made by only four of the companies being studied here and varies from \$5.00 to \$10.00. The only comment which need be made is one related to the previous discussion of the proportionate increase in the amount of risk. If a company charges \$10.00 for every ambulance driver, and the hospital employs but two

on twelve-hour shifts, it need not pay so high a premium as a hospital which employs three drivers on eight-hour shifts, the latter probably operating less hazardously.

It is important that hospital administrators focus attention upon the component factors which enter into the computation of the rate to be charged for hospital malpractice insurance. In order to show the approximate extent of variation which would be found among different size hospitals, the premiums for selected hospitals of 25, 100, and 500 beds can be approximated readily by inspection. The variation among the companies with regard to the total premiums paid yearly for hospitals of these three capacities would be material.

A few companies vary the basis for their charges from those discussed above or combine new factors with them. For the sake of completeness these are given in Tables 6-10.

The data given in Table 6 are interesting because they introduce three factors not found in the rates of most of the eleven companies discussed previously. First, the company divides its rates between Greater New York and elsewhere in New York, increasing the charge for beds from 25 to 50 per cent for Greater New York. Second, it differentiates between the rates to be charged for beds in a charity hospital and beds in other types. The amount of difference is material. In Greater New York the charge for each charity hospital bed is \$3.00; in all others, \$16.00. Elsewhere in New York the charge is \$2.00 for a charity hospital bed and \$12.00 for all others. The increases from hospital beds other than charity may be taken as a partial measure of the increased liability and the subsequent expenses and losses arising from malpractice claims in the state.

The third and last factor of importance in Table 6 is the radium charge. There is an addition of \$50 to the premium if radium is used in the hospital and is owned by the hospital. It was explained in the chapter dealing with contracts that practically all companies demanded a waiver excluding this coverage unless an added premium was paid. In the experience of this company the additional coverage is worth \$50—a large amount—indicating the feeling that allegations of malpractice involving the use of radium are serious and expensive.

In many respects Table 6 is comparable with Table 7. The charges made for all items, excluding beds, are identical. The table is valuable, however, for two reasons. It divides hospitals according to legal status into three groups—charity, part charity and part pay, and pay only—and defines the part-charity and part-pay hospitals as those of “at least 25 per cent charity.”⁷ This classification raises a question which cannot be answered finally, namely, whether the legal status of hospitals should be determined according to the variations in the proportions of free and pay beds in hospitals or according to the purposes for which the hospital is operated, i.e., as one serving the community and legally prohibited from paying out any funds as profits to individuals or as proprietary establishments from which profits may be withdrawn. The distinction between hospitals operating for and those not for profit would seem to have definite advantages over an arbitrary percentage bed variation basis.

The other factor in Table 7 which is interesting is that the company, instead of measuring decreasing variations in risk due to increases in the number of

beds as above or below 50, has proceeded to schedule the rates downward with increases in size and diminishing liability due to charitable status. In this case hospitals are classified according to bed capacity as follows: 100 or less, 100–150,

TABLE 7*

HOSPITAL MALPRACTICE INSURANCE RATES FOR
COMPANY M, WRITING IN NEW YORK STATE
AS OF DECEMBER 1, 1936

Basis of Charge	Charity Hospi- tal	Part Charity and Part Pay†	Pay Only
<i>Bed charge (each):</i>			
100 or less.....	\$ 1.50	\$ 2.00	\$ 3.00
100–150.....	1.25	1.75	2.50
150–200.....	1.00	1.50	2.00
Over 200.....	0.75	1.00	1.50
<i>Professional staff charge (each):</i>			
Physicians, surgeons, dentists, externs.....	10.00	10.00	10.00
<i>Pharmacist charge (each):</i>			
Pharmacist.....	5.00	5.00	5.00
<i>X-ray charge (each):</i>			
X-ray operators—physicians.....	15.00	15.00	15.00
X-ray operators—technicians.....	5.00	5.00	5.00
Radium.....	50.00	50.00	50.00
<i>Ambulance charge (each):</i>			
Ambulance drivers.....	5.00	5.00	5.00
<i>Laboratory charge (each):</i>			
Laboratory technicians..	5.00	5.00	5.00
<i>Minimum premium.....</i>	50.00	75.00	100.00

* New York State Insurance Department rate file.

† At least 25 per cent charity.

150–200, and over 200 beds. In an earlier chapter the considerations determining risk were examined and the opinion expressed that it was reasonable to assume that, with increases in size, the hospital administration could take advantage of specialized departmentation, with probably better supervision and direction. It is a question whether the changes would

⁷ From New York State Insurance Department rate file.

be great enough within a range of from 100 to 200 beds or whether larger class intervals should be set. However, it is possible that the rates charged for the different size groups do fairly approximate the changes in the amount of risk due to the factor of number of beds.

Table 8 and 9 are sufficiently similar to make it possible to discuss them to-

TABLE 8*

HOSPITAL MALPRACTICE INSURANCE RATES FOR
COMPANY N, WRITING IN NEW YORK STATE
AS OF DECEMBER 1, 1936

Basis of Charge	Rate per Bed	Clinic Doc- tors	Mini- mum Premium
General and Maternity†			
Not for profit‡.....	\$ 1.50	\$ 5.00	\$ 50.00
For profit:§			
Upstate.....	6.00	10.00	75.00
Greater New York....	16.00	10.00	75.00
Mentals and Nervous, etc.			
Not for profit:			
First 50 beds.....	\$ 4.50	.....	\$150.00
Over 50 beds.....	3.00	.....	150.00
For profit:			
First 50 beds.....	16.00	.....	150.00
Over 50 beds.....	10.00	.....	150.00

* Source: New York State Insurance Department rate file.

† Including special hospitals other than mental and nervous hospitals.

‡ Hospital operating under charitable charter.

§ Hospital operating under private charter.

gether. The hospitals are classified (1) as to types of cases treated, whether general or mental; (2) as to their legal status; (3) as to location in Greater New York or elsewhere; and (4) according to size—under or over 50 beds. The basis for the rate in each case is the charge per bed and the charge for each clinic doctor. The minimum premiums are indicated. It is interesting to note that the bed charge for the nonprofit mental and nerv-

ous hospital is three times that for the general hospital, while there is no difference between the charges for the two types of profit hospitals under 50 beds and a lesser difference between those in excess of 50 beds. A distinction is also made between the bed charge for profit in Greater New York and elsewhere in New York.

TABLE 9*

HOSPITAL MALPRACTICE INSURANCE RATES FOR
COMPANY O, WRITING IN NEW YORK STATE
AS OF DECEMBER 1, 1936

Basis of Charge	Rate per Bed	Clinic Doc- tors	Mini- mum Premium
General and Maternity†			
Not for profit.....	\$ 1.50	\$ 5.00	\$ 50.00
For profit:			
Upstate.....	6.00	11.25	75.00
Greater New York....	16.00	11.25	75.00
Mental and Nervous, etc.			
Not for profit:			
First 50 beds.....	\$ 4.50	.....	\$150.00
Over 50 beds.....	3.00	.....	150.00
For profit:			
First 50 beds.....	15.00	.....	150.00
Over 50 beds.....	10.00	.....	150.00

* Source: New York State Insurance Department rate file.

† Including special hospitals other than nervous and mental hospitals.

The last company to be studied computes its rates on bases indicated in Table 10. Hospitals are divided, according to size, into three groups, according to legal status as "not for profit and/or having 25 per cent or more charity cases" and "for profit and/or having less than 25 per cent charity cases." There are no charges for physicians, surgeons, pharmacists, or ambulance drivers.

It is interesting to observe that, in computing the bed and bassinet charges,

the prevalent practice of charging the flat rate for all beds in the hospital within

TABLE 10*

HOSPITAL MALPRACTICE INSURANCE RATES FOR
COMPANY P, WRITING IN NEW YORK STATE
AS OF DECEMBER 1, 1936

Basis of Charge	Up to 15†	Over 150 and under 301	Over 300
I. Method Based on Total Bed and Bassi- net Capacity			
<i>Bed and bassinet charge</i> (each):†			
Hospitals not operated for profit and/or having 25% or more charity cases. . . .	\$ 2.25	\$ 1.50	\$ 0.90
Hospitals operated for prof- it and/or having less than 25% charity cases. . . .	5.00	4.00	3.00
II. Optional Method Based on Average Occupancy			
<i>Bed and bassinet charge</i> (each):			
Hospitals not operated for profit and/or having 25% or more charity cases. . . .	\$ 2.70	\$ 2.25	\$ 1.35
Hospitals operated for prof- it and/or having less than 25% charity cases. . . .	6.00	5.00	4.00
Both Methods			
<i>X-ray charge (each):</i>			
Physician employed by hospital and using X-ray for diagnosis and treat- ment alone.	\$50.00	\$50.00	\$50.00
<i>Radium charge (each):</i>			
Physicians employed by hospital or if radium is owned, borrowed, or rented by the hospital. . .	25.00	25.00	25.00

large charity hospital of 350 beds and 40 bassinets, the bed and bassinet charge is computed as follows:⁸

150 beds	at \$2.25 each. . . .	\$337.50
150 beds	at 1.50 each. . . .	225.00
50 beds	at 0.90 each. . . .	45.00
40 bassinets	at 0.45 each. . . .	18.00

Total premium charge. . . . \$625.50

The study of rates charged for hospital malpractice insurance by companies writing in New York State indicates (1) a material variation in the methods used in computing rates; (2) the items or factors in the hospital for which specific charges are made; (3) that the sums charged for identical items in the premiums of different companies for the same coverage vary, in many cases, more than 100 per cent; and (4) that it necessarily follows that hospitals buying insurance at the higher rates are paying more than those insuring with companies writing at the lower rates. Presumably rates should vary with the amount of risk, but it is questionable whether those charged by some companies do vary in a manner which is equitable to both the policyholder and the company.

Statistics on experience are designed to measure the losses resulting from underwriting a particular kind of risk. They are customarily expressed as loss ratios, which show the relation of the losses incurred to the total premiums written. In Tables 11, 12, and 13 the experience data for New York State, New York City, and New York State exclusive of New York City from 1931 to 1934 inclusive are presented.

In answer to the frequent complaints of hospital administrators that rates for hospital malpractice insurance are unnecessarily high, the experience of New

* Source: New York State Insurance Department rate file.

† For each bassinet in the maternity department charge one-half of the above rates, using the lowest bed rate charged for the hospital on the basis of bed capacity or average occupancy.

one bed capacity or average occupancy group is not followed. Illustrated for a

⁸ From New York State Insurance Department rate file.

York State should prove illuminating, since this state and probably Massachusetts are the two where the court deci-

o.497, with the highest—o.713—occurring in 1932 and the lowest—o.385—in 1931. Compared with the fluctuating

TABLE 11*

EXPERIENCE DATA FOR HOSPITAL MALPRACTICE INSURANCE IN NEW YORK STATE
DURING POLICY YEARS 1931-34 INCLUSIVE AS OF DECEMBER 31, 1935

Experience by Classifications (Basis of Exposure)	Policy Year	Exposure	Total Premium Written	Losses Incurred	Excess Losses over Total Premium	No. of Claims	Loss Ratio
Number of risks (hospitals).....	{ 1931	41.2	\$ 8,782	\$ 920	.....	4	0.105
	{ 1932	45.7	9,753	4,744	.....	9	.486
	{ 1933	44.1	8,746	825	.....	3	.094
	{ 1934	34.1	7,517	1,140	.....	6	0.152
	Total.....	165.1	\$ 34,798	\$ 7,629	.....	22	0.219
Number of beds.....	{ 1931	682.4	\$ 4,537	.....	.....	2	0.023
	{ 1932	2,058.3	4,755	\$ 107	.....	.....	.....
	{ 1933	2,274.7	5,599	.....	.....	1	0.079
	{ 1934	3,147.1	6,573	520	.....	.....	.....
	Total.....	8,162.5	\$ 21,464	\$ 627	.....	3.	0.029
Number of employees (physicians and surgeons).....	{ 1931	71.6	\$ 845	.....	.....	1	1.271
	{ 1932	81.5	951	\$ 1,209	.....	.....	.....
	{ 1933	79.5	924	.....	.....	.....	.....
	{ 1934	85.5	981	.....	.....	.....	.....
	Total.....	318.1	\$ 3,701	\$ 1,209	.....	1	0.327
Cash receipts.....	{ 1931	.....	.....	.....	.....	.....	.....
	{ 1932	.....	.....	.....	.....	.....	.....
	{ 1933	.....	.....	.....	.....	.....	.....
	{ 1934	30,000.0	\$ 731	.....	.....	.....	.....
	Total.....	30,000.0	\$ 731	.....	.....	.....	.....
Flat charge.....	{ 1931	.....	\$ 50,562	\$ 23,998	.....	58	0.475
	{ 1932	.....	51,335	41,568	.....	48	.810
	{ 1933	.....	54,511	27,270	.....	28	.500
	{ 1934	.....	51,424	31,069	.....	90	0.604
	Total.....	.....	\$207,832	\$123,905	.....	224	0.596
All bases.....	{ 1931	.....	\$ 64,726	\$ 24,918	.....	62	0.385
	{ 1932	.....	66,794	47,628	.....	60	.713
	{ 1933	.....	69,780	28,095	.....	31	.403
	{ 1934	.....	67,226	32,729	.....	97	0.487
	Total.....	.....	\$268,526	\$133,370	.....	250	0.497

* Source: Compiled by the National Bureau of Casualty and Surety Underwriters, December 17, 1936, from reports to the New York State Insurance Department.

sions defining the legal liability of charitable hospitals are most stable.

An examination of these tables shows that the average loss ratio in New York State for the years 1931-34 inclusive was

losses experienced in other lines, such as life, fire, and workmen's compensation insurance, hospital malpractice insurance appears to be profitable in New York State.

However, while New York is the only state which has these data, it must be remembered that it does not necessarily conditions of legal liability are in a greater state of flux in many other places, and for that reason conditions for writing

TABLE 12*

EXPERIENCE DATA FOR HOSPITAL MALPRACTICE INSURANCE IN NEW YORK CITY
DURING POLICY YEARS 1931-34 INCLUSIVE AS OF DECEMBER 31, 1935

Experience by Classifications (Basis of Exposure)	Policy Year	Exposure	Total Premium Written	Losses Incurred	Excess Losses over Total Premium	No. of Claims	Loss Ratio
Number of risks (hospitals).....	1931	11.9	\$ 4,111	\$ 443	.....	1	0.108
	1932	11.2	2,932	3,422	.....	6	1.167
	1933	11.9	2,779	105	.....	1	0.038
	1934	11.0	3,895	140	.....	4	0.036
Total.....		46.0	\$ 13,717	\$ 4,110	.....	12	0.300
Number of beds.....	1931	398.3	\$ 3,904		.....		
	1932	1,374.0	3,562	\$ 82	.....	2	0.023
	1933	1,488.1	3,788		.....		
	1934	2,383.4	4,589	20	.....		0.004
Total.....		5,643.8	\$ 15,843	\$ 102	.....	2	0.006
Cash receipts.....	1931				.....		
	1932				.....		
	1933				.....		
	1934	30,000.0	\$ 731		.....		
Total.....		30,000.0	\$ 731		.....		
Flat charge.....	1931		\$ 37,676	\$ 22,786	.....	56	0.605
	1932		39,725	39,271	.....	45	.989
	1933		42,091	22,854	.....	25	.543
	1934		36,706	24,193	.....	76	0.659
Total.....			\$156,198	\$109,104	.....	202	0.698
All bases.....	1931		\$ 45,691	\$ 23,229	.....	57	0.508
	1932		46,219	42,775	.....	53	.925
	1933		48,658	22,959	.....	26	.472
	1934		45,921	24,353	.....	80	0.530
Total.....			\$186,489	\$113,316	.....	216	0.608

* Source: Compiled by the National Bureau of Casualty and Surety Underwriters, December 17, 1936, from reports to the New York State Insurance Department.

reflect the experience of the rest of the country. In addition, there is the fact that the amounts of losses probably vary in different locations for unknown reasons, as is the case in fire insurance.⁹ It will be shown in a later chapter that con-

hospital malpractice insurance approximate the ideal in New York State.

As might be expected, conditions vary extremely between New York City and the rest of the state, with the loss experience in New York City being much greater than elsewhere. In New York City the average loss ratio for the years 1931-34 inclusive was 0.608 as con-

⁹ Robert Riegel and H. J. Loman, *Insurance Principles and Practice* (New York: Prentice-Hall, Inc., 1929), p. 234.

trusted with 0.244 for the hospitals outside New York City. It would seem that the rates charged for New York State outside New York City were too high quite probable that many companies writing in New York State, with their limited experience in hospital malpractice insurance, do not set separate rates

TABLE 13*
EXPERIENCE DATA FOR HOSPITAL MALPRACTICE INSURANCE IN NEW YORK STATE
EXCLUDING NEW YORK CITY DURING POLICY YEARS 1931-34 INCLUSIVE
AS OF DECEMBER 31, 1935

Experience by Classifications (Basis of Exposure)	Policy Year	Exposure	Total Premium Written	Losses Incurred	Excess Losses over Total Premium	No. of Claims	Loss Ratio
Number of risks (hospitals).....	1931	29.3	\$ 4,671	\$ 477	.....	3	0.102
	1932	34.5	6,821	1,322	.....	3	.194
	1933	32.2	5,967	720	.....	2	.121
	1934	23.1	3,622	1,000	.....	2	0.276
Total.....		119.1	\$21,081	\$ 3,519	.....	10	0.167
Number of beds.....	1931	284.1	\$ 633	.....	.....	.....	.....
	1932	684.3	1,193	\$ 25	.....	.....	0.021
	1933	786.6	1,811	.....	.....	.....	.....
	1934	763.7	1,984	500	.....	1	0.252
Total.....		2,518.7	\$ 5,621	\$ 525	.....	1	0.093
Number of employees (physicians and surgeons).....	1931	71.6	\$ 845	.....	.....	.....	.....
	1932	81.5	951	\$ 1,209	.....	1	1.271
	1933	79.5	924	.....	.....	.....	.....
	1934	85.5	981	.....	.....	.....	.....
Total.....		318.1	\$ 3,701	\$ 1,209	.....	1	0.327
Flat charge.....	1931	.....	\$12,886	\$ 1,212	.....	2	0.094
	1932	.....	11,610	2,297	.....	3	.198
	1933	.....	12,420	4,416	.....	3	.356
	1934	.....	14,718	6,876	.....	14	0.467
Total.....		.....	\$51,634	\$14,801	.....	22	0.287
All bases.....	1931	.....	\$19,055	\$ 1,689	.....	5	0.089
	1932	.....	20,575	4,853	.....	7	.236
	1933	.....	21,122	5,136	.....	5	.243
	1934	.....	21,305	8,376	.....	17	0.393
Total.....		.....	\$82,037	\$20,054	.....	34	0.244

* Source: Compiled by the National Bureau of Casualty and Surety Underwriters, December 17, 1936, from reports to the New York State Insurance Department.

and that those charged for New York City were too low, which resulted in the upstate hospitals' paying premiums which contributed to the insuring of a higher risk class, namely, the hospitals in New York City. In actual practice it is for New York City. The unfavorable conditions in New York City can be attributed in large part to the claim consciousness of the public, the activities of lawyers in promoting claims, and the absence of a strong sense of community

responsibility toward the hospitals. In smaller cities the people are more intimately acquainted with the services rendered by hospitals. The personal relations between the hospital, the doctor, and the patient are much more definitely emphasized in the smaller places.

It is important to note that in 1934 there was a decrease of about 25 per cent in the number of risks written in New York City but that the total premium volume for that year changed very little. It is quite probable that, after the losses experienced in 1932, the companies increased rates and also refused to write those hospitals which had been individually responsible for causing particularly heavy losses.

A way to determine the average cost of a claim can be derived from Tables 12 and 13. Dividing the number of claims into the total losses incurred, it is found that the average cost of a claim in New York City was \$525 and, in New York State exclusive of New York City, \$590. The higher figure for Upper New York State is probably due to the added cost of rendering claim investigation and adjustment service away from the metropolitan area. On the whole, it would seem evident that an average cost of \$500-\$600 per claim would be embarrassing to those hospitals having a series or "run" of malpractice claims.

In order to obtain a comparative evaluation of the relative hazardousness of writing hospital malpractice insurance in New York State from 1931 to 1934, a parallel can be drawn between the experience of insurance companies in writing hospital malpractice insurance and physicians' and surgeons' malpractice insurance (see Tables 14 and 15). Physicians' and surgeons' malpractice insurance is the closest approximation to hospital malpractice insurance, since the lat-

ter is essentially an outgrowth of the former, and together they comprise the largest portion of that group known as professional malpractice insurance.

The experience data given in Table 11 are the same as those presented previously in Table 5, except that the data, in-

TABLE 14*

EXPERIENCE DATA FOR HOSPITAL MALPRACTICE INSURANCE BY COMPANIES IN NEW YORK STATE DURING POLICY YEARS 1931-34 INCLUSIVE AS OF DECEMBER 31, 1935

COMPANY	EXPERIENCE BY CLASSIFICATION				
	Premiums Written	Losses Incurred	Excess Losses	No. of Claims	Loss Ratio
A.....	\$ 26,776	\$ 6,555	.....	16	0.245
B.....	667	20	.....	.....	.030
C.....	89	.....	.....	.....	.....
D.....	1,354	.....	.....	.....	.....
E.....	1,719	541	.....	2	.315
F.....	569	.....	.....	.....	.....
G.....	961	.....	.....	.....	.....
H.....	2,038	90	.....	3	.044
I.....	1,220	443	.....	1	.363
J.....	14,748	82	.....	2	.006
K.....	6,775	1,709	.....	2	.252
L.....	14,801	1,039	.....	6	.070
M.....	2,132	25	.....	.....	.012
N.....	41	.....	.....	.....	.....
O.....	806	.....	.....	.....	.....
P.....	1,985	.....	.....	.....	.....
Q.....	29	.....	.....	.....	.....
R.....	191,816	122,866	.....	218	0.641
All companies combined..	\$268,526	\$133,370	.....	250	0.497

* Source: Compiled by the National Bureau of Casualty and Surety Underwriters, December 17, 1936.

stead of being arranged according to the basis of exposure, are classified according to insurance companies. A similar classification is followed in Table 12 for the experience data regarding physicians and surgeons. It should be noted that the company designated as Company C does not write physicians' and surgeons' insurance and that Company S does not write hospital malpractice insurance.

In the first place, it is important to note that the loss ratio for physicians and surgeons is much more unfavorable than that for hospital malpractice insurance.

TABLE 15*

EXPERIENCE DATA FOR PHYSICIANS' AND SURGEONS' MALPRACTICE INSURANCE IN NEW YORK STATE DURING POLICY YEARS 1931-34 INCLUSIVE AS OF DECEMBER 31, 1935

COMPANY	EXPERIENCE BY CLASSIFICATION				
	Premiums Written	Losses Incurred	Excess Losses	No. of Claims	Loss Ratio
A.....	\$ 52,234	\$ 22,910		77	0.439
B.....	405				
C†.....					
D.....	9,806	181		2	0.018
E.....	110				
F.....	129				
G.....	5,778	45		1	0.008
H.....	4,362				
I.....	5,392	7,081		7	1.313
J.....	1,538				
K.....	2,615				
L.....	9,287	13,929		9	1.500
M.....	6,339	4,937		18	0.779
N.....	4,070	782		10	0.192
O.....	3,005				
P.....	104				
Q.....	711				
R.....	1,295,908	913,659	\$39,684	671	0.705
S‡.....	6,262	3,250		1	0.519
All companies combined.....	\$1,408,108	\$966,774	\$39,684	796	0.687

* Source: Compiled by the National Bureau of Casualty and Surety Underwriters, December 17, 1936.

† Company does not write physicians' surgeons' and malpractice insurance.

‡ Company does not write hospital malpractice insurance.

The average loss ratio for physicians and surgeons was 0.687 for the four-year period, while that for hospitals was 0.497. The highest loss ratio of any company for hospital malpractice insurance was 0.641, while that for physicians and surgeons was 1.500.

A second fact which is impressive is that two companies play dominating roles in writing these two forms of coverage, namely, Company R and Company A. The larger, Company R, has a premium volume of \$122,866 for hospital malpractice insurance and \$1,295,908 for physicians' and surgeons' insurance. It is significant that this company, which has over two-thirds of the hospital malpractice business in the state, has the highest loss ratio, in spite of the fact that a few large losses to companies writing a small volume will have a much greater tendency to increase their loss ratios. The only explanation for this comparatively unfavorable position of Company R in the hospital malpractice insurance field in New York State may be attributed either to an extreme liberalism in accepting marginal risks or to charging lower rates than other companies writing hospitals. Both factors may have been present. The position of pre-eminence which Company R maintained in the field of physicians' and surgeons' insurance in New York State is due to the fact that this company carried the group insurance contract for the New York State Medical Society during this period. Company A, which wrote the second largest volume, fared better than average for each kind of insurance, having a loss ratio of 0.245 for hospital malpractice insurance and 0.439 for physicians' and surgeons'.

CHAPTER VI

CLAIMS

THE proceedings of the claim department writing hospital malpractice insurance do not differ materially from those of other forms of casualty insurance.

First, there is the receipt of the claim notice sent by the hospital, which is promptly examined to determine whether the claim comes within the time and scope of coverage provided by the policy.

Second, there is the investigation of the claim. This involves getting the essential facts, as free as possible from conjectures or premature conclusions. Through written reports obtained by correspondence with the hospital and through data collected by a skilled investigator of the insurance company, the claim department obtains facts surrounding the alleged act of malpractice and the names of persons involved who may be used as witnesses.

Third, there is the examination and analysis of the claim to determine whether it is fair or unwarranted. The insurance company must be able to determine whether the amount of damages asked is in reasonable proportion to the injuries alleged. At the same time there must be an attempt made to estimate accurately the value, or, as it is more technically known, the reserve, required for the claim. This is an approximation of the monetary loss anticipated in the possible payment of the claim. The setting-aside of this reserve is required by the insurance laws of all the states and is intended primarily to prevent the transfer of current earnings to investments, surplus, or profits, thus leaving inadequate liquid

funds for the payment of deferred losses and expenses.

Fourth, there is the employment of judgment regarding when to settle and when to carry a claim into court. This is usually decided jointly by the legal and claim departments of the insurance companies. In passing judgment on whether or not to carry a claim into court, numerous factors are involved requiring familiarity with legal conditions in the particular jurisdictions and an approximation of the probable cost of defense with some consideration of the reaction of the hospital to being exposed to the publicity of court proceedings.

The importance of employing competent claim personnel for this type of insurance should be stressed. No company can render proper service to policyholders if its claim adjusters are not familiar with hospital organization and operation. The fundamentally different authority relationships, particularly between the professional groups and the hospital, as found in different types of hospitals and even within the same type, require familiarity with the entire field and understanding of the problems which hospitals must deal with in their endeavor to render conscientious service.

With regard to legal problems, the claim adjuster must know the limits of hospital liability as determined by the statutes and court decisions applied in his jurisdiction. He must also be a keen analyst of public relations. The extent to which he can estimate the attitude of juries toward the insurance company and

the hospital which is being sued will have a bearing on the judgment of how to proceed in any given claim.

Before proceeding to the statistical examination of claims, a few illustrative cases will be described briefly to show how the claim department functions jointly with the legal department. The examples cited are taken from the file of a prominent insurance company. They present representative problems of investigation and defense which arise and indicate the comparative weighting of the factors which must be considered in judging how to deal with malpractice claims.

The first case shows the value of the legal service provided by the insurance contract when apparently liability does not exist against the hospital, but when, nevertheless, suit is brought and must be defended.¹

In April, 1930, a workman sustained a crushed thumb of the right hand in an industrial accident. Several operations were undergone in the course of the following two years, but satisfactory results did not follow. Finally, a new surgeon decided upon a pedicle skin graft which was performed at the X—Hospital in California. In spite of the most careful and detailed attention the result was disastrous. Gangrene set in, requiring amputation of the thumb and all fingers. The patient had epileptic seizures, a relapse of a former condition, not previously known to the surgeon. Finally, the patient recovered mentally and physically but was permanently disabled from engaging in his trade.

He filed suit in February, 1933, for \$75,000 against the surgeon, the hospital, and each hospital employee who had attended him. Neither the company's attorneys nor those for the surgeon who was insured by two other companies could see any liability on the part of any of the defendants. Still, the plaintiff's lawyers were determined to proceed to trial, and weeks were spent in making a complete investigation and preparing the defense.

¹ Cases cited were prepared by an insurance company from its claim file.

The trial took place in March, 1934, lasting nine days. The defense was complete in every point, so much so that at the conclusion of the trial, the court granted the plea of the defense for nonsuits in favor of each and every defendant. . . . This was a costly case to prepare and try, the time given to it was unusually long, and a multitude of witnesses were involved. The total costs of the defense of the hospital and its employees amounted to nearly \$1,800.

The following account shows the persistence of some claimants in attempting to obtain damages as well as the need of careful selection, training, and supervision of nursing personnel.

In December, 1931, a pneumonia patient was in the oxygen room of the X—Hospital of Wisconsin. The arrangement in the room included a shelf about three feet over the patient's head and on which was a barometer, weighing three and a half pounds, and a pull chain hanging directly over the patient's chest to enable her to turn the room light on and off. A student nurse . . . looped the chain behind the barometer and left the patient, who later, in the dark, pulled the chain. The barometer was dislodged, falling on the patient's head and inflicting a deep and painful wound. It apparently did not interfere with her recovery from pneumonia, and the wound itself healed without incident.

While the cause of the accident was inexcusable, there was no permanent impairment or disfigurement. Nevertheless, suit was filed in November, 1932, for \$2,000 damages. It was tried in October, 1933; ably defended by the company's attorneys; and a directed verdict given in favor of the defendant, the court holding that a charitable hospital was exempt from damages for such an accident, due to the act of its employee. The plaintiffs were stubborn, however, and an appeal was taken. This was argued before the higher court in February, 1934, and the decision of the lower court was upheld. . . . If the patient's attorneys had joined the nurse in their complaint as a co-defendant, it is likely that some damages would have been assessed against her. . . .

This case, trifling as it was, cost the company nearly \$200 in attorneys' fees and incidental expenses, thus saving the hospital such expense and providing them with expert legal service and defense.

A third case describes alleged malpractice arising from circumstances involving difficult and complicated surgical care. It shows how skilled attorneys who are specialists in professional liability defense can deal effectively with situations in which less specialized legal representatives may be at a loss through unfamiliarity with the technical difficulties and professional relationships surrounding the accident.

In March, 1933, a man and wife brought suit against the X—Hospital of California and an obstetrician for injuries resulting from a sponge left in the uterus during delivery at the hospital in June, 1932.

The hospital was insured by the company, the surgeon carrying no insurance. The suit was tried in September, 1933, and ten days in court were required. The suffering and bodily injury to the patient were serious and evident, and the case was a difficult one to defend. The company's attorney was successful in convincing the jury of the true facts, which, briefly, were that the hospital was not liable for the act of its employed graduate nurse; that during the delivery she was the assistant of the obstetrician and under his direct orders; that this particular delivery, a caesarean section, was a difficult one; that serious hemorrhage was involved, and rapid work was necessitated by this condition; that there was no time to make a sponge count; that overlooking the sponge was therefore not negligence or malpractice; and that, while it added to post-delivery complications, the uterine condition was so subnormal that the subsequent operative procedure which was performed, namely, the removal of the uterus, would have been required in any event. While the company's defense was, of course, supplied only for the insured hospital, the evidence supported by the expert witnesses provided showed not only that the hospital was not liable but also that there was no malpractice on the part of either the physician or the nurse. The jury consequently returned a verdict in favor of both defendants.

The defense, as can be realized from the foregoing, was a costly one. The company, in accordance with the policy contract, paid all costs including attorneys' fees, witness fees, and incidental expenses amounting to a total of \$1,350.

Another claim illustrates the distinction between the responsibility of hospital nurses as contrasted with that of private nurses for acts performed by them and also points out the seriousness of burn claims.

Hot water bottles applied to a patient suffering from shock after a herniotomy and appendectomy caused several severe burns. This occurred in April, 1933, at the X—Hospital of Minnesota. The patient was in the charge of his own physician and a private nurse, but the bottles were prepared and applied by nurses employed by the hospital. The burns required three to four weeks' hospitalization beyond the expected time for recovery from the operation. The hospital was clearly liable for the negligence of its nurses, and with its required consent the claim was compromised for \$2,500 by the company in October, 1933, before threatened suit was filed.

Instead of examining the claim practices of individual insurance companies, it is felt that more profit will be derived, both by hospitals and by the insurance companies writing a small volume of hospital malpractice insurance, if a fairly large and representative number of claims of one company are studied in detail. The data presented in Tables 16 and 17 represent the experience of one of the three leading companies. A careful and systematic inspection of these data will provide answers to some of the questions perplexing both hospital administrators and liability insurance executives.

One of the most prominent facts disclosed in Tables 16 and 17 is that hospitals approved by the American College of Surgeons had losses and expenses paid totaling \$39,504.18 for 92 insured hospitals totaling 14,644 beds, while hospitals not approved by the American College of Surgeons paid losses and expenses amounting to \$22,502.19 for 32 hospitals of 1,660 beds. Expressed in terms of ra-

TABLE 16*

CLAIMS OF HOSPITALS APPROVED BY THE AMERICAN COLLEGE OF SURGEONS CLOSED DURING 1934

State	Loss Paid	Expense Paid	Date of Malpractice	Nature of Malpractice	Disposition of Claim	Beds†
Iowa.....	\$ 210.00	.....	7-33	Heat-lamp burn	Compromised	175
Calif.....	100.00	\$ 2.00	11-31	Nursing error	Compromised	200
Ill.....	.....	.....	8-33	Nursing error	Dropped‡	400
Minn.....	.....	.....	3-33	Nursing error	Dropped	250
Ill.....	.....	.....	5-33	Nursing error	Dropped	\$
N.H.....	100.00	.....	12-33	Hot-water-bottle burn	Compromised	150
Calif.....	100.00	.....	1-34	Hot-water-bottle burn	Compromised	100
Okla.....	.....	.....	10-33	Nursing error	Dropped	200
Minn.....	75.00	.....	10-33	Hypodermoclysis	Compromised	100
Wyo.....	93.75	.....	11-32	Nursing error	Compromised	100
Calif.....	.....	337.37	6-33	Burns by drug	Dismissed	150
La.....	242.05	.....	11-33	Hot-water-bottle burn	Compromised	100
Tenn.....	.....	110.00	12-31	Bone fracture	Tried and won	35
Calif.....	.....	.....	2-30	Unknown	Not covered	250
Ga.....	.....	507.88	11-30	Nursing error	Tried and won	150
Calif.....	200.00	.....	1-34	Hot-water-bottle burn	Compromised	250
Calif.....	.....	.....	9-33	Hypodermic	Dropped	350
N.Y.....	.....	0.50	11-33	Hot-water-bottle burn	Dropped	200
Miss.....	.....	75.00	12-32	Nursing error	Dismissed	50
Mich.....	.....	.....	11-33	Anesthetic	Dropped	100
N.Y.....	.....	11.50	2-32	Nursing error	Dismissed	350
Wyo.....	400.00	.....	10-31	Hot-water-bottle burn	Tried and lost	50
Minn.....	.....	.....	8-33	Nursing error	Dropped	150
Minn.....	.....	.....	5-33	Unknown	Dropped	\$
Minn.....	.....	.....	5-33	Hypodermic	Dropped	\$
S.C.....	.....	.....	7-27	Veneral disease	Dropped	50
Iowa.....	400.00	.....	3-32	Hot-water-bottle burn	Compromised	100
Calif.....	300.00	45.00	8-33	Hypodermoclysis	Compromised	250
Wis.....	.....	192.44	12-31	Nursing error	Tried and won	150
Calif.....	.....	.....	4-33	Dressing left in incision	Dropped	50
Calif.....	.....	.....	12-33	Obstetrics, injured child	Dropped	250
Minn.....	.....	.....	12-32	Hypodermic	Dropped	\$
Utah.....	12.50	.....	3-34	Hypodermoclysis	Compromised	200
Ill.....	.....	.....	7-32	Unknown	Not covered	150
N.Y.....	750.00	5.00	9-33	Heating-pad burn	Compromised	100
Mass.....	47.50	.....	11-33	Dressing left in incision	Compromised	150
Mich.....	.....	10.00	9-33	Poultice burn	Dropped	200
N.Y.....	.....	10.00	2-33	Bone fracture	Dropped	\$
Me.....	.....	.....	2-33	Hypodermic	Dropped	100
Wash.....	.....	294.00	2-33	Surgical operation, gynecology	Dismissed	700
N.Y.....	.....	.....	1-34	Nursing error	Dropped	\$
Tex.....	125.00	10.00	3-34	Hypodermic	Compromised	10
N.Y.....	.....	.....	1-34	Nursing error	Dropped	\$
Calif.....	.....	50.00	9-31	General major surgery	Tried and won	\$0
Mo.....	.....	.....	9-33	Nursing error	Dropped	150
Miss.....	.....	.....	9-33	Direct heat burn	Dropped	50
Ill.....	.....	.....	3-33	Treatment-caused infection	Dropped	300
Mass.....	.....	.....	3-34	Obstetrics, injury to child	Dropped	450
Mo.....	.....	.....	10-33	Burns from drugs	Dropped	300
Ill.....	.....	.....	8-33	Treatment-caused infection	Dropped	\$
Mo.....	.....	.....	4-34	Unknown	Not covered	\$
Calif.....	.....	10.00	3-34	Nursing error	Dropped	\$
Calif.....	650.00	90.00	1-33	Hot-water-bottle burn	Compromised	100

* Source: Data compiled from the claim experience of one company writing a large volume of hospital malpractice insurance, modified in part to conceal identity of the hospitals concerned.

† The bed capacities of the hospitals are in round numbers.

‡ "Dropped" means dropped by plaintiff.

§ One or more claims closed for the particular hospital earlier in the same year.

TABLE 16—Continued

State	Loss Paid	Expense Paid	Date of Malpractice	Nature of Malpractice	Disposition of Claim	Beds†
Calif.....	\$ 875.00	\$ 160.10	5-32	Nursing error	Compromised	300
N.Y.....			3-34	Hot-water-bottle burn	Dropped	250
Minn.....	600.00	20.00	5-33	Anesthetics	Compromised	100
W.Va.....		57.50	9-33	Abdominal surgery	Dismissed	50
Ohio.....		27.50	10-33	Nursing error	Dropped	150
Tex.....	500.00	120.85	4-32	Direct electric burn	Compromised	100
Calif.....	50.00	52.50	11-33	Hot-water-bottle burn	Compromised	50
Calif.....	1,150.00	68.00	11-33	Hot-water-bottle burn	Compromised	50
Calif.....		1,783.82	7-32	Plastic surgery	Dismissed	50
N.J.....			11-33	Superficial X-ray burn	Dropped	100
Calif.....			4-34	Hypodermoclysis	Dropped	150
Calif.....	206.76		4-34	Anesthetics	Compromised	50
Utah.....	400.00		4-34	Nursing error	Compromised	50
Calif.....		24.88	5-34	Nursing error	Dropped	50
Calif.....		18.04	8-33	Postoperative care	Dropped	150
Calif.....			5-34	Dressing left in incision	Dropped	50
Calif.....	250.00	211.40	3-33	Treatment-caused infection	Compromised	50
Fla.....			11-32	Bone surgery	Dropped	300
Mass.....			1-34	General major surgery	Dropped	50
Calif.....		67.32	11-32	Obstetrics, mother	Dismissed	50
Minn.....			9-33	Dressing left in incision	Dismissed	100
Ill.....			6-34	Hypodermic	Dropped	250
Calif.....		10.00	8-33	Nursing error	Dropped	50
Va.....	1,708.84	634.45	11-30	Nursing error	Compromised	200
Tenn.....			5-34	Throat surgery	Dropped	50
Mo.....			9-33	Burn, direct heat	Dropped	50
Calif.....			8-33	Treatment-caused infection	Dropped	50
Calif.....			8-33	Nursing error	Dropped	50
Wash.....		205.00	4-30	Bone fracture	Dismissed	50
Calif.....			6-33	Nursing error	Dropped	50
Calif.....	175.00	320.10	4-32	Hot-water-bottle burn	Compromised	50
N.Y.....	100.00	5.00	11-33	Alpine-lamp burn	Compromised	100
Tex.....	725.00	142.25	2-34	Hypodermic	Compromised	50
Va.....	2,511.50		2-32	Nursing error	Compromised	50
Ill.....			10-33	Bone fracture	Dropped	50
Calif.....	400.00	195.05	11-32	Burns, rectal anesthesia	Compromised	50
Minn.....		3-202.95	4-32	Nursing error	Tried and won	300
Calif.....	50.00	79.80	6-34	General major surgery	Compromised	50
Kan.....	250.00	12.35	10-33	Hot-water-bottle burn	Compromised	50
Mich.....	1,200.00	165.00	8-32	Burned with iodine	Compromised	50
Fla.....	2,000.00	10.00	11-32	Nursing error	Compromised	35
Okla.....		100.00	7-30	Unnecessary operation	Dismissed	50
N.Y.....	500.00	5.00	4-30	Hot-water-bottle burn	Compromised	100
W.Va.....	3,500.00		8-33	Throat surgery	Compromised	200
Calif.....		87.47	2-33	Eye surgery	Dismissed	200
Calif.....	250.00	111.95	2-33	Nursing error	Compromised	150
Minn.....			3-33	Hot-water-bottle burn	Dropped	250
Minn.....			7-34	Throat surgery	Dropped	50
Tenn.....			9-32	Bone surgery	Dropped	50
Ohio.....	1,000.00	8.00	3-32	Hypodermoclysis	Compromised	150
Tenn.....		339.60	1-33	Autopsy	Tried and won	150
Minn.....	15.00		7-34	Negligent attendance	Compromised	50
Wis.....			5-34	Negligent attendance	Dropped	200
Wis.....			11-33	Throat surgery	Dropped	50
Mo.....		150.00	8-32	General minor surgery	Dismissed	35
Mass.....		0.25	1-33	Nursing error	Dismissed	50
N.C.....			6-34	Hypodermic	Dropped	50
Iowa.....			5-34	Hot-water-bottle burn	Dropped	100
Minn.....	150.00		10-34	Hot-water-bottle burn	Compromised	150
Wis.....	100.00		10-34	Hot-water-bottle burn	Compromised	150

TABLE 16—*Continued*

State	Loss Paid	Expense Paid	Date of Malpractice	Nature of Malpractice	Disposition of Claim	Beds†
W. Va.			6-33	Bone fracture	Dropped	50
Calif.			8-34	Nursing error	Dropped	50
Minn.	\$ 100.00	\$ 5.00	12-33	Direct heat burn	Compromised	\$
Md.	3,000.00	35.00	5-34	Direct heat burn	Compromised	200
Mass.		266.10	6-27	Negligent attendance	Dismissed	100
Ill.			9-33	Bone fracture	Dropped	150
Iowa	100.00		1-34	Nursing error	Compromised	\$
Minn.			12-32	Nursing error	Dropped	150
Minn.	900.00		4-34	Nursing error	Compromised	\$
Calif.			11-34	Nursing error	Dropped	\$
Minn.			7-34	Hypodermic	Dropped	\$
Minn.			6-34	Negligent attendance	Dropped	900
Tenn.	126.30	262.25	7-33	Hypodermic	Compromised	100
Canada	300.00	79.25	10-34	Nursing error	Compromised	100
Calif.			3-34	Negligent attendance	Dropped	\$
Minn.			7-34	Unknown	Dropped	\$
Mich.	45.85		9-33	Bone fracture	Compromised	50
Wash.			5-34	Throat surgery	Dropped	\$
Wis.		60.93	3-34	Ear surgery	Dismissed	50
Mass.			9-28	Nursing error	Dropped	50
Minn.			9-32	Unknown	Not covered	150
W. Va.		593.78	9-33	Bone fracture	Dismissed	\$
W. Va.	1,000.00		11-28	General major surgery	Compromised	100
Total	\$28,045.05	\$11,459.13				14,644

tios, the startling contrast becomes apparent that losses and expenses paid for the approved hospitals were \$2.69 per bed in contrast with \$13.55 per bed for those hospitals not approved. This would support the statement made tentatively in an earlier chapter concerning the favorable risk presented by hospitals approved by the American College of Surgeons. The discrepancy between the figures for the two groups is so great that insurance companies should consider giving preferential rates to hospitals which have achieved approval. For, under a system of premium charges where no difference in rates exists or where only a small discount in rates is granted, the approved hospitals are paying premiums which support the excessive losses resulting from the writing of the nonapproved hospitals. At the present such a distinction is recognized by only a very few companies, and in these the dis-

counts in rates are not commensurate with the extreme variation in losses and expenses paid for the two groups.

An important problem both to insurance companies and to hospitals is to determine whether hospitals which have had claims presented in the past are likely to be poor risks in the future. This can be indicated to some extent by the tables, which show that the 92 approved hospitals had 136 claims closed during the year 1934, and the 32 nonapproved hospitals had 48 claims closed. Expressed numerically, this represents an excess of half again as many claims closed within one year over the number of hospitals written. The frequency with which this duplication of claims in the same institution arises can be seen in the column "Beds," for every section mark (§) recorded in place of the bed capacity means that the claim is the second, third, or fourth against some hospital enumerated above.

TABLE 17*

CLAIMS OF HOSPITALS NOT APPROVED BY THE AMERICAN COLLEGE
OF SURGEONS CLOSED DURING 1934

State	Loss Paid	Expense Paid	Date of Malpractice	Nature of Malpractice	Disposition of Claim	Beds†
N.Y.		\$ 210.00	10-27	Nursing error	Dismissed	35
Calif.	\$ 750.00	14.50	8-33	Heat-lamp burn	Compromised	15
Ind.			1-33	Abdominal surgery	Dismissed	15
Ill.			5-33	Anesthesia	Dropped‡	250
Calif.		1.75	1-33	Hypodermic	Dismissed	8
Miss.	1,510.35	201.25	1-32	Hypodermoclysis	Compromised	25
N.C.		260.25	12-27	Bone fracture	Dismissed	25
N.Y.	200.00	5.00	11-33	Heating-pad burn	Compromised	50
Calif.	150.00	15.00	12-33	Hot-water-bottle burn	Compromised	100
Idaho	250.00		8-31	Hot-water-bottle burn	Compromised	10
Miss.		430.40	8-30	Exposure in ambulance	Tried and won	25
Minn.			11-33	Nursing error	Dropped	25
Minn.			11-33	Hypodermic	Dropped	25
Minn.			1-34	Unknown	Not covered	25
Minn.			3-33	X-ray burn	Dropped	25
Ill.			3-33	Treatment-caused infection	Dropped	25
Minn.	225.00	7.50	1-34	Electric-pad burn	Compromised	25
Okla.	2,850.00		9-33	Hypodermoclysis	Compromised	25
N.Y.	5,220.01	397.38	5-26	Burned by electric heat	Compromised	25
Colo.	2,000.00	293.70	6-33	Hot-water-bottle burn	Compromised	25
Okla.	500.00		6-33	Dressing left in incision	Compromised	25
Mass.	260.00		8-29	Hot-water-bottle burn	Compromised	25
Calif.			6-33	Negligent attendance	Dropped	35
Ill.		3.00	10-32	Massage	Dropped	25
Idaho	425.00		6-34	Infra-red lamp burns	Compromised	150
Minn.	25.00		10-32	Obstetrics, child	Compromised	25
Minn.			3-34	Hypodermic	Dropped	25
Tenn.			6-33	Nursing error	Dropped	100
Ill.	500.00	20.00	2-31	Nursing error	Compromised	25
Calif.			6-34	Infra-red lamp burn	Dropped	50
Minn.		541.80	11-32	Hypodermoclysis	Tried and won	25
Wis.	241.25		8-34	Hot-water-bottle burn	Compromised	50
S.D.	900.00		5-34	Hot-water-bottle burn	Compromised	50
Minn.	1,275.00	45.00	3-33	Nursing error	Compromised	25
N.Y.		5.50	11-30	Treatment-caused infection	Dismissed	50
Wash.	375.00	138.00	3-34	Direct electric burn	Compromised	10
Mont.		268.65	8-33	Surgery without consent	Dismissed	50
Wis.			4-33	Nursing error	Dropped	150
Idaho			7-30	Dressing left in incision	Dropped	15
Tex.	500.00	10.00	11-33	Hot-water-bottle burn	Compromised	25
Calif.	150.00	146.00	10-31	Nursing error	Compromised	100
Calif.	37.50	134.54	4-34	Technical assault	Compromised	100
N.D.			8-32	Deep X-ray burn	Dropped	10
Calif.			9-34	Hot-water-bottle burn	Dropped	25
Va.		430.50	11-31	Dressing left in incision	Tried and won	25
Colo.			12-33	Negligent attendance	Dropped	25
N.Y.		578.36	10-29	Anesthesia	Tried and won	25
Calif.			12-33	Wrong diagnosis	Dropped	25
Total...	\$18,344.11	\$4,158.08				1,660

* Source: Data compiled from the claim experience of one company writing a large volume of hospital malpractice insurance, modified in part to conceal identity of the hospitals concerned.

† The bed capacities of the hospitals are in round numbers.

‡ "Dropped" means dropped by plaintiff.

§ One or more claims closed for the particular hospital earlier in the same year.

In Table 3² the frequency of the nature of claims was examined by groups but no effort was made to evaluate their comparative seriousness. Using the data contained in Tables 16 and 17, such an evaluation may now be attempted by relating the losses and expenses paid to the nature of malpractice and, incidentally, to the disposition of the claim.

An examination of these columns discloses the prominent fact that burns of all kinds and nursing errors are the two most expensive causes of malpractice. Burns resulted in losses and expenses paid totaling \$24,491.11 and, it is important to note, were in total slightly more costly to the insurance company among hospitals not approved by the American College of Surgeons, being \$12,377.34, as against those approved totaling \$12,113.77. This can be explained in part by the amounts paid in the burn claims among the nonapproved hospitals, one of which was over \$5,600 and another \$2,200. It is also significant to correlate the burns with the disposition of the claims and to note that in only a very few instances were the claims dropped by the plaintiff. Almost all of them had to be compromised by the company.

Nursing errors are the second group of claims which are serious because of the amounts paid and, in addition, because of their frequency. Mr. Harry A. Prevost, superintendent of the Personal Accident and Health and Professional Liability Department of the United States Fidelity and Guaranty Company, when asked what he considered the most important way in which hospitals could contribute to a reduction of malpractice claims, advised first of all that hospital administrators should improve the quantity and quality of nursing service. The correctness of this judgment is amply

supported by the evidence contained in Tables 16 and 17. Among the approved hospitals nursing errors resulted in losses and expenses paid totaling \$14,299.24 and among the nonapproved hospitals, \$2,346.00. The high losses among approved hospitals applies both to the number of claims and to the amounts, some compromised settlements costing more than \$2,000, and one claim which was tried and won exceeding \$3,200 in expenses.

Before leaving the financial analysis of the tables, something should be said about a comment which is frequently made, namely, that hospital malpractice insurance is not really insurance but a contract to render legal protective services when claims arise. It is interesting to notice that the approved hospitals had losses paid totaling \$28,251.79 as against \$11,459.03 expenses paid and that the nonapproved hospitals had losses amounting to \$18,344.11 against expenses of \$4,158.08. On the basis of costs, the indemnity provision of the insurance contract is not a mere camouflage for rendering legal services.

In enumerating the functions of the claim department, stress was laid on the importance of judging correctly when to compromise a claim and when to take it into court. Many hospital administrators think that insurance companies take a large proportion of malpractice claims through court proceedings. That this is not the case is disclosed in Table 18, which is derived from the column headed "Disposition of Claim." An exceedingly small number of claims were tried in the courts, only 11 claims for the approved and nonapproved hospitals combined, and 10 of these resulted in judgments in favor of defendant hospitals. An almost equal number of claims were compromised as were dropped by plaintiffs. It

² Chap. ii, p. 14.

is important to note that, of those dropped, the larger proportion were claims against the approved hospitals.

A question frequently asked is whether certain states or sections present more claims than do others. The data in Tables 16 and 17 throw some light on this issue. Before proceeding to any analysis by states, it should be pointed out that the sample provided is not sufficiently extensive to correspond accurately to the statistical distribution of hospitals throughout the United States. But it is enough to indicate two areas which have a particularly large number of claims. These are Minnesota and California, especially southern California. Minnesota had a total of 29 claims, and California 44. No precise reasons can be given to account for the excessive number of hospital malpractice claims arising in these states, but the testimony of those who have had experience in these regions may be presented as partial answer.

In Minnesota the courts have held that charitable hospitals are on a par with private corporations with respect to liability for acts of malpractice committed on patients. This, coupled with the antagonistic attitude of the socialistically minded population toward insurance companies, particularly in some sections, accounts for the unfavorable malpractice conditions.

In California the conditions of medical and hospital practice are in a state of agitation. Evidences of commercialism more or less foreign to the rest of the country are found there.

Finally, the court interpretations of hospital liability for acts of negligence in rendering care and in allied medicolegal matters are unsettled and conflicting. As long as these conditions remain, the hospitals in these regions will be costly or prohibitive insurance risks. This does

not mean that other regions do not present certain distinct problems. The amount of risk varies with states and even small sections of states, but this is not disclosed by the available data. Insurance companies with a large volume of hospital malpractice business are able to determine the variation in the amount of risk and change their base rates in direct proportion to the absolute differences in the amount of risk present. The extent of this variation as found in one company ranges from an increase of 80 per cent to

TABLE 18*

DISPOSITION OF CLAIMS CLOSED IN APPROVED AND NONAPPROVED HOSPITALS DURING 1934*

Disposition of Claim	Hospitals Approved by American College of Surgeons	Hospitals Not Ap- proved by American College of Surgeons
Compromised.....	48	21
Dropped by plaintiff.....	61	16
Dismissed.....	16	6
Tried and won.....	6	4
Tried and lost.....	1	0
Not covered.....	4	1
Total claims closed.....	136	48

* Experience of one company.

a decrease of 30 per cent. Another company increases its base rate 100 per cent for two states in the North Pacific region.

In an earlier chapter the deferment of claims was mentioned as an obstacle to the establishment of scientific rates for this type of insurance. It is possible now to examine the data given in Tables 16 and 17 under the column "Date of Malpractice" and determine the extent of deferment of claims. A study of the data discloses that there is no significant variation between approved and nonapproved hospitals. It will therefore be possible to study the combined claims for both groups of institutions, bearing

in mind that the data refer only to claims closed during 1934. The total number of claims closed in 1934 was 184. Of these, 49 arose during 1934, of which only 11 were closed in the last six months of that year. Of the 184 claims closed in 1934, 81 arose in 1933, 50 of which occurred during the last half of the year. During 1932, 27 claims occurred which were deferred until 1934; during 1931, 9 claims were deferred; and, during 1930, 9 again. In 1928 there were 2 claims; in 1927, 4, and in 1926, 1. The total number of claims closed in 1934 arising in the years 1926-31 inclusive is 25. Out of a total of 184 claims closed, this is not a large proportion. But when it is recognized that some of these claims may not have been made until toward the end of the period permitted by the statute of limitations in the particular state and that the insurance company may no longer be writing the involved hospital's malpractice insurance but must still act as the hospital's defendant, since the malpractice allegedly occurred during the contract period, it becomes evident that the losses and expenses which may arise are difficult to estimate and to allocate in the rate structure. Added to this is the difficulty of defending long-deferred claims when nurses, interns, and hospital employees who may be called upon to act as witnesses for the defense have left the hospital and cannot be traced. Finally, there is the possi-

bility that the hospital may not keep adequate medical records and the defense be rendered almost hopeless by the fragmentary information the available record offers.

Before leaving the study of claims, another aspect of the subject concerning the causes of claims deserves mention. Attention has been called to the variety of institutional and community factors which are concerned, but mention should be made of one which, for want of a better name, can be called "grudge" claims. Insurance executives dealing with hospital malpractice claims are almost unanimous in stressing their importance. They feel that many claims would never be started if hospitals used better judgment in their relations with patients who are justly grieved or imagine themselves to be. Hospitals frequently irritate patients to the point where they will sue the hospitals for malpractice whether the claim be justified or merely a reflection of the patient's spite. Such cases are numerous and sufficiently serious to deserve attention. They result from various causes of dissatisfaction, the most important being bill-collection methods, involving such practices as the threat to detain patients who fail to pay before leaving the institution and misunderstandings about the charges or the time of payment. "Grudge" claims are of common occurrence and merit thoughtful consideration by hospital administrators.

CHAPTER VII

THE LEGAL ASPECTS OF LIABILITY

IN THE preceding chapters frequent reference was made to the legal aspects of hospital liability for damages due to personal injury claims. It was pointed out that hospital administrators have generally believed themselves more or less immune from the payment of such damages, in spite of the fact that in very few states are hospitals completely exempt.

Charges of malpractice are based upon breaches of duty imposed by law. In general, the duty of hospitals is to use ordinary and reasonable care in providing medical and nursing services to the patients they accept for treatment. The quality of the treatment which the patient receives is not to be affected in any way by the amount which the patient pays, even if this is less than the cost of the hospital services rendered. In the case of charity hospitals the problems are far from settled. Court interpretations vary extensively among the states and even within sections of states.¹

In deciding whether or not charity hospitals are liable for torts, the courts go from one extreme, Illinois,² which does

¹ The subject of "The Tort Liability of Charitable Institutions" was reviewed in the *American Bar Association Journal* of January, 1936, by John A. Appleman. He examined the leading decisions in every state and showed the various theories which have been employed in determining the degree to which charities have been held liable or not liable for torts.

The author suggests that those readers who desire an up-to-date statement concerning legal aspects of hospital liability review recent cases because of the new decisions which have been rendered since this report was prepared.

² *Parks v. Northwestern University*, 218 Ill. 381, 75 N.E. 991 (1905). See also *Johnson v. City of Chi-*

ago, 258 Ill. 494, 101 N.E. 960 (1913), and *Hogan v. Chicago Lying-in Hospital*, 35 Ill. 42, 166 N.E. 461 (1929).

not permit recovery, to the other, Minnesota,³ where it has been held that charities are liable in the same degree as private corporations. Often in cases where states do not differ materially regarding the recovery allowed, the courts employ reasoning which is mutually antagonistic to arrive at the same conclusions. From the point of view of charity hospitals, there are three basic theories to support the denial of the right to recover, although others, such as the theory of implied waiver and that requiring the exercise of due care in the selection of employees, have been used from time to time. First, there is the theory that trust funds cannot be diverted from their designated purpose in order to pay claims for personal damages. Second, there are the arguments revolving around the concept that it would be against public policy to pay the funds of a charity for such purposes. Third, there is the common-law doctrine of *respondeat superior*, which holds that an employer is responsible for the acts of his employees and therefore may be held liable.

In view of the extensive use which has been made of statistical and actuarial data from the state of New York and the frequent references made to its legal attitude toward the liability of charitable hospitals, it will be worth while to cite at some length from a recent case in which the arguments for and against the vari-

ago, 258 Ill. 494, 101 N.E. 960 (1913), and *Hogan v. Chicago Lying-in Hospital*, 35 Ill. 42, 166 N.E. 461 (1929).

³ *Mulliner v. German Evangelical Synod*, 144 Minn. 393, 175 N.W. 699 (1920.)

ous defenses of hospitals are nicely stated. The case, reviewed among the briefs on "Legal Decisions of Interest to Hospitals" in the *Journal of the American Hospital Association*, is an action by a paying patient arising from injuries sustained in the hospital's ambulance. The jury gave a verdict for the plaintiff, and the case was appealed by the defendant.⁴ That court passed similarly in favor of the plaintiff, and the case was taken to the Court of Appeals, which affirmed the decision arrived at by the two lower courts.

In the words of the New York Court of Appeals, the

plaintiff, who had been a paying patient in a hospital of the defendant-appellant, a charitable corporation, was being removed in its ambulance to her home. Negligence of the driver brought the ambulance into collision with another vehicle and the plaintiff suffered injuries for which she had a judgment which has been affirmed. On these facts there is squarely presented for the first time in this court the question whether a charitable institution (not itself in default in the performance of any non-delegable duty) should be declared exempt from liability to a beneficiary for personal harm caused by the negligence of one acting as its mere servant or employee. Cf. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 52 L.R.A. (N.S.) 505, Ann. Cas. 1915 C. 581.

The case for immunity must rest on the hypothesis that a recipient of the benefit impliedly waives any claim for damages resulting from torts in the administration of a charity, a theory that would be inapplicable were the plaintiff a stranger to this hospital. See *Hordern v. Salvation Army*, 199 N.Y. 233, 238-240, 92 N.E. 626, 32 L.R.A. (N.S.) 62, 139 Am. St. Rep. 889; *Hamburger v. Cornell University*, 240 N.Y. 328, 329-340, 148 N.E. 539, 42 A.L.R. 955; *Johnsen v. Staten Island Hospital Inc.*, 271 N.Y. 519, 2 N.E. (2d) 674; *Kellogg v. Church Charity Foundation*, 128 App. Div. 214, 218, 112 N.E. 566. A prop may be found in the consideration that to compel payment of damages to a beneficiary would be to limit charitable activities and to dry up the sources of charitable donation. In

a case not quite the same, the strongest argument for nonliability was stated in these words: "There can certainly be no principle of natural justice which would require one engaged in charitable work to be liable to the recipients of his charity for the wrongs of others. If he use reasonable care in the selection of the means and is guilty of no wrong himself, he ought not to be answerable to those who accept the charity for the wrongs of servants whom he has to employ to make it effective." *Wallace v. John A. Casey Co.*, 132 App. Div. 35, 44, 116 N.Y.S. 394, 401.

"On the other side, it is answered that the 'waiver' doctrine is pretty much a fiction (*Philips v. Buffalo General Hospital*, 239 N.Y. 188, 146 N.E. 199); that to impose liability is to beget careful management; and that no conception of justice demands that an exception to the rule of respondeat superior be made in favor of the resources of a charity and against the person of a beneficiary injured by the tort of a mere servant or employee functioning in that character. It is our judgment that the greater weights are in this scale.

"Moreover, the now declared public policy of the State is that persons damaged by the torts of those acting as its officers and employees need not contribute their losses to the purposes of government. Court of Claims Act, par. 12-a. We think it would not be a harmonious policy that would require this plaintiff to put up with her injuries on the score that the appellant is a charitable corporation." Cf. *Murtha v. New York Homeopathic Medical College and Flower Hospital*, 228 N.Y. 183, 126 N.E. 722.⁵

By way of a summary the following constructive criticisms may be made. In examining the underlying issues in these theories of law, it may be pointed out that the trust-fund theory and the doctrine of *respondeat superior* arise out of earlier interpretations of public policy and have no validity except as they reflect public policy today. The trust-fund doctrine states that funds donated to a charity cannot be used for any except their original purpose. The logic behind this position was (1) that a donor could not be presumed to foresee that there might be claims of damages due to per-

⁴ 248 App. Div. 632, 289 N.Y.S. 756.

⁵ *Sheehan v. North Country Community Hospital*, 273 N.Y. 163, 7 N.E. (2) 28 (1937).

sonal injuries against the charity and (2) that the donor would not wish to see his gift diminished or impaired by the collection of such damages. The public policy aspect of the trust fund was eloquently expressed by one jurist when he said that "it is not difficult to discern that private gift and public aid would not long be contributed to feed the hungry maw of litigation, and charitable institutions of all kinds would ultimately cease or become greatly impaired in their usefulness"⁶ if trust funds were not kept inviolate. The fact of the matter is that donors can and should foresee that claims arise. Furthermore, it would seem reasonable, and in the light of public policy desirable, that an injured recipient of care in charitable institutions should be fairly compensated for injuries sustained at the hands of the charity's employees. While it might be pointed out that the tortfeasor is fundamentally liable and that the right to recover may be exercised against him, as a practical measure it gives no basis for recovery, since such persons are usually without funds. Therefore, it necessarily falls upon institutions to meet the costs of reasonable claims arising from injuries due to negligent care.

A classification of the several stages of liability of charities among the different states has been arranged as follows:

1. No liability to any claimant on tort.
2. Liability of the charity on injuries connected with profit making, as where a building is operated for revenue, and not as part of the charity.
3. Liability to strangers injured in the operation of the charity.
4. Liability to patrons who pay for service, as pay patients in a charity hospital.
5. Liability for all torts, including those to charity patients.⁷

⁶ *Perry v. House of Refuge*, 63 Md. 21, 52 Am. Rep. 495, 501 (1885).

⁷ "Charity Institutions Are Being Held Liable for Injuries," *Casualty Insurer*, October, 1936, p. 35.

Applying the above stages of liability to specific states jointly with the various theories, it is both interesting and important to note the extreme confusion which exists in this field of law. For example, Minnesota⁸ has recently passed upon this question of liability and holds charitable institutions to the same standards as private individuals or business corporations.

The soundest decisions on this subject are to be found in the decisions of New York,⁹ California,¹⁰ Connecticut,¹¹ Indiana,¹² Iowa,¹³ Louisiana,¹⁴ Montana,¹⁵ New Jersey,¹⁶ North Carolina,¹⁷ Ohio,¹⁸ Oklahoma,¹⁹ Texas,²⁰ Utah,²¹ Virginia,²² and West Virginia.²³

⁸ *Geiger v. Simpson Methodist Church*, 174 Minn. 393, 219 N.W. 463 (1928).

⁹ *Darcy v. Presbyterian Hospital*, 202 N.Y. 259, 95 N.E. 395. See also *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914), and *Hamburger v. Cornell University*, 240 N.Y. 328, 148 N.E. 543 (1925).

¹⁰ *Ritchie v. Long Beach Hospital Association*, 34 P. 2d 771 (1934).

¹¹ *Cashman v. Meriden Hospital*, 117 Conn. 915, 169 A. 915 (1933).

¹² *St. Vincent's Hospital v. Stine*, 195 Ind. 350, 144 N.E. 237 (1924).

¹³ *Mikota v. Sisters of Mary*, 183 Iowa 1378, 168 N.W. 219 (1918).

¹⁴ *Foye v. St. Francis Sanatorium*, 2 La. App. 305 (1925).

¹⁵ *Borgeas v. Oregon Shortline R. Co. et al.*, 73 Mont. 407, 236 Pac. 1069 (1925).

¹⁶ *Daniels v. Rahway Hospital*, 160 A. 644 (1932).

¹⁷ *Cowans v. North Carolina Baptist Hospitals, Inc.*, 197 N.C. 66, 147 S.E. 672 (1929).

¹⁸ *Taylor v. Flower Deaconess Home and Hospital*, 104 Ohio State 61, 135 N.E. 287 (1922).

¹⁹ *City of Shawnee v. Roush*, 101 Okla. 60, 223 P. 354 (1923).

²⁰ *Baylor University v. Boyd*, 18 S.W. 2d 700 (1929).

²¹ *Gitzhoffen v. Sisters of Holy Cross Hospital Association*, 32 Utah 46, 88 P. 691 (1907).

²² *Weston's Adm'x. v. Hospital of St. Vincent of Paul*, 131 Va. 587, 107 S.E. 785 (1921).

²³ *Roberts v. Ohio Valley General Hospital*, 98 W.Va. 476, 127 S.E. 318 (1925).

The general consensus of the courts among these states is that charities are not liable to their beneficiaries but that strangers or invitees may recover. These states have been in the vanguard, destroying the position that charities cannot be held liable. The general trend in these states is that injured persons shall not be made to suffer unduly owing to the negligent acts of charities' employees. The theory followed by these states may be summarized broadly as follows: the beneficiary of a charity may succeed in his action against the charity if the charity does not establish that it exercised due care in the selection and retention of its servants and employees.

Missouri is notable for its well-reasoned cases which combine the defense of public policy with the trust-fund doctrine.²⁴

Colorado,²⁵ Kentucky,²⁶ Maine,²⁷ Maryland,²⁸ Oregon,²⁹ Pennsylvania,³⁰ and South Carolina³¹ all seem to exempt the charity in the ordinary case. That is, some special or unusual circumstance must be present to create liability. An example of this is the now rather famous

nuisance doctrine of South Carolina, which allows recovery for injury to property adjacent to the charitable institution but prohibits and denies the right of recovery for personal injury suffered at the hands of the charity.³²

A number of states present rules which are peculiar to their own jurisdictions. Nebraska,³³ Michigan,³⁴ Nevada,³⁵ and Rhode Island³⁶ bar beneficiaries of the charity from any recovery under all circumstances but hold that, where a stranger to the charity is plaintiff, the charitable institution is subject to the same liabilities as any wrongdoer.

In Kansas³⁷ actions by recipients of the charity or by strangers to the charity may be successfully maintained upon proof of negligence in the selection and retention of the employees of the charitable hospital.

In Georgia³⁸ the Kansas ruling on this question was followed in part, but it was further held that pay patients could recover, regardless of the care used in the selection of servants, up to the amount of money received from all such pay patients.

In Tennessee,³⁹ although recovery was

²⁴ *Robert v. Kirksville College of Osteopathy and Surgery*, 16 S.W. 2d 625 (1929). See also *Eads v. Y.W.C.A.*, 325 Mo. 577, 29 S.W. 2d 701 (1930), and *Hope v. Barnes Hospital*, 227 Mo. App. 1055, 55 S.W. 2d 319 (1932).

²⁵ *Brown v. St. Luke's Hospital Association*, 85 Colo. 167, 247 P. 740 (1929).

²⁶ *Emery v. Jewish Hospital Association*, 193 Ky. 400, 236 S.W. 577 (1921), and *Pikeville Methodist Hospital v. Donahoo*, 221 Ky. 538, 299, S.W. 159 (1927).

²⁷ *Jensen v. Maine Eye and Ear Infirmary*, 107 Me. 408, 78 A. 898 (1910).

²⁸ *Loeffler v. Trustees of Sheppard and Enoch Pratt Hospital*, 130 Md. 265, 100 A. 301 (1917).

²⁹ *Hamilton v. Cornwallis General Hospital Association*, 146 Ore. 168, 30 Pac. 2d 9 (1934).

³⁰ *Gable v. Sisters of St. Francis*, 227 Pa. 234, 75 A. 1087 (1910).

³¹ *Vermillion v. Women's College of Due West*, 104 S.C. 197, 88 S.E. 649 (1916).

³² *Peden v. Furman University*, 155 S.C. 1, 151 S.E. 907 (1930).

³³ *Sibilia v. Paxton Memorial Hospital*, 121 Neb. 860, 238 N.W. 751 (1931).

³⁴ *Downes v. Harper Hospital*, 101 Mich. 555, 60 N.W. 24 (1894), and *Bruce v. Henry Ford Hospital*, 254 Mich. 394, 236 N.W. 813 (1931).

³⁵ *Bruce v. Y.M.C.A.*, 51 Nev. 372, 277 P. 798 (1929).

³⁶ *General Laws of Rhode Island*, c. 248, sec. 95, p. 1011 (1923).

³⁷ *Nicholson v. Atchison, Topeka & Santa Fe Hospital Association*, 97 Kans. 480, 155 P. 920 (1916). See also *Webb v. Vought*, 127 Kans. 799, 275 P. 170 (1929).

³⁸ *Georgia Baptist Hospital v. Smith*, 139 S.C. 101 (1927). See also *Morton v. Savannah Hospital*, 96 S.E. 887 (1918).

³⁹ *Gamble v. Vanderbilt University et al.*, 138 Tenn. 550, 243 S.W. 304 (1918).

limited to strangers to the charity, this was extended to allow damages for the maintenance of a nuisance.

In Massachusetts⁴⁰ it has been held that wherever property is being used in order to raise money for purposes of the charity, in contrast to its being used in the administration of the charity, recovery may be had for torts committed upon that property or in the course of its maintenance and operation. Other states which apparently apply the same rule are Arkansas,⁴¹ Arizona,⁴² Mississippi,⁴³ Washington,⁴⁴ Wisconsin,⁴⁵ and Wyoming.⁴⁶ The last two states, however, seem to impose absolute liability upon the charity where the injury is received as a result of improperly maintained premises.

In North Dakota, South Dakota, Delaware, Idaho, New Mexico, Florida, and Vermont the subject of the liability of charities for torts has never been treated. It might well be that when cases arise for final decision in these jurisdictions the majority rule as expressed in New York, etc.,⁴⁷ will be followed.

In order to summarize the analysis of charities' liability given above, Table 19, indicating liability to beneficiaries joint-

ly with that to strangers, is presented. The liability of charities to strangers is given in a column parallel with the liability to beneficiaries in order to indicate the progression toward increased liability.

It should be remembered in examining Table 19 that often the decisions in a particular state are not in harmony and that certain theories have been raised in the courts of some states and not in others.

Considering the freedom from liability which charities enjoyed before the turn of the century, the new decisions point toward the application of increasing liability. This tendency has a direct bearing on the amount of risk which hospitals may incur, for clearly the legal determination of hospital liability is the primary contributor to the risk which hospitals present and largely controls whether damages must be paid for injuries or whether hospitals will be able to maintain their traditional defenses.

The methods employed in computing rates for different kinds of insurance are dependent on the character and quantity of data available which have been derived from the experience that one or more companies have had in writing this particular kind of insurance. For example, life insurance rates are based, in large part, on mortality tables which show what past experience has been. By examining these data, a competent actuary can compute and determine by mathematically accurate means what future experience will probably be. In this case rates can be measured with remarkable accuracy for comparatively long periods of time.

In the case of workmen's compensation insurance and certain other types of insurance there is a complicating factor in the computing of rates in that new ele-

⁴⁰ *McKay v. Morgan Memorial Co-op Industries and Stores Inc.*, 272 Mass. 121, 172 N.E. 68 (1930). This decision was later clarified by the same judge in *Reavey v. Guild of St. Agnes*, 284 Mass. 300, 187 N.E. 557 (1933).

⁴¹ *Arkansas Midland Railroad Co. v. Pearson*, 98 Ark. 399, 135 S.W. 917 (1911).

⁴² *Southern Methodist Hospital and Sanatorium of Tucson v. Wilson*, 46 P. 2d 118 (1935).

⁴³ *Mississippi Baptist Hospital v. Moore*, 156 Miss. 676, 126 So. 465 (1930).

⁴⁴ *Bise et ux. v. St. Luke's Hospital*, 43 P. 2d 4 (1935).

⁴⁵ *Morrison v. Henke*, 165 Wis. 166, 160 N.W. 173 (1915).

⁴⁶ *Bishop Randall Hospital v. Hartley*, 24 Wyo. 408, 160 P. 385 (1916).

⁴⁷ Above, p. 54.

ments, such as the reduction of machine hazards through the use of safeguards, may arise in the future. When consid-

fecting rates are usually short run. In this field a method of experience rating has been devised by Mr. Albert W. Whitney,

TABLE 19*
LIABILITY OF CHARITABLE INSTITUTIONS FOR TORTS, BY STATES

State	B†	S‡	State	B†	S‡
New England:			North Central:		
Maine.....	No	No§	Minnesota.....	Yes	Yes
New Hampshire.....	Yes	Yes	Iowa.....	No||	Yes
Vermont.....			Missouri.....	No	No
Massachusetts.....	No	No§	North Dakota.....		
Rhode Island.....	No	Yes	South Dakota.....		
Connecticut.....	No||	Yes	Nebraska.....	No	Yes
			Kansas.....	No||	No
Middle Atlantic:			West South Central:		
New York.....	No||	Yes	Arkansas.....	No||	?
New Jersey.....	No||	Yes	Louisiana.....	No	Yes
Pennsylvania.....	No	No§	Oklahoma.....	No||¶	Yes
			Texas.....	No||	Yes
South Atlantic:			Mountain:		
Delaware.....			Montana.....	No||	Yes
Maryland.....	No	No§	Idaho.....		
Virginia.....	No||	Yes	Wyoming.....	No||	No§||
West Virginia.....	No	Yes	Colorado.....	No	No§
North Carolina.....	No||	Yes	New Mexico.....		
South Carolina.....	No	No§	Arizona.....	No||	No||
Georgia.....	No¶	No||	Utah.....	No||	Yes
Florida.....			Nevada.....	No	Yes
East North Central:			Pacific:		
Ohio.....	No||	Yes	Washington.....	No||	No||
Indiana.....	No||	Yes	Oregon.....	No	No§
Illinois.....	No	No	California.....	No||¶	Yes
Michigan.....	No	Yes			
Wisconsin.....	No||	No§||			
East South Central:					
Kentucky.....	No	No§			
Tennessee.....	No||	No§			
Alabama.....	No¶	Yes			
Mississippi.....	No||	?			

* Source: "Charity Institutions Are Being Held Liable," *Casualty Insuror*, October, 1936, p. 35.
† B = Beneficiaries.
‡ S = Strangers.
§ Liable in speciable circumstances.
|| Charity immune if it exercised care in selecting servants ("servants" includes doctors and nurses).
¶ Liable to pay patients.

ered from the long-time trend, these elements do not repeat themselves with as little variation as do the factors in life insurance. Therefore, measurements af-

of the National Bureau of Casualty and Surety Underwriters.⁴⁸

⁴⁸ "The Theory of Experience Rating," *Proceedings of the Casualty Actuarial and Statistical Society of America*, LV, No. 10 (1918), 274.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

THE need of hospital malpractice insurance is becoming more apparent as administrators are impressed with the growing frequency of claims. Alleged claims of malpractice are exceedingly troublesome to administrators, not alone because of their increasing frequency, but because of the suddenness with which they arise and the unpredictable manner in which they may occur, both as to time and as to place. If not dealt with effectively by persons informed as to the legal aspects of claim adjustment as well as in a number of other pertinent factors, such as the psychology of the claimant, the attitudes of local juries, and the possible injury to the hospital's reputation, they may prove costly to the hospital. The financial losses arise from two sources; from investigation and defense of the claim and from the cost of compromise settlement or damages if the case is tried and lost.

To meet malpractice risk, hospitals may transfer the risk to a professional risk-bearer for a definite financial consideration, they may attempt self-insurance by setting aside definite reserves from their own funds, or they may make no provision. The first course is recommended, because one of the most important services which hospitals need when claims are brought is the guidance of competent legal experts in this specialized field of law.

An analysis of the factors affecting the quantity of malpractice risk was made. The groups of elements which contributed were, namely, the size of the hospi-

tal and the diseases treated; the internal organization and operation of the hospital, including professional, skilled, and unskilled personnel as well as the hospital structure and equipment; and, finally, the attitude of the community toward the hospital.

There are approximately twenty insurance companies writing hospital malpractice insurance, most of them, if not all, writing it on an accommodation basis. Only a few of these have a large premium volume and operate throughout the United States. The majority of the carriers have a very restricted volume, ranging from two or three contracts upward to a few hundred. Owing to the highly specialized technical features connected with writing this line, particularly in determining whether a hospital is a desirable risk and in handling the complex problems arising with claims, many small underwriters have preferred to drop hospital malpractice insurance.

No standard hospital malpractice insurance contract has been developed. Careful scrutiny of a number of representative contracts indicates many important points in which coverage necessary to hospitals is absent or indeterminate. The most important omissions and exclusions are failure to provide for acts of negligence in the hospital outpatient department, in the ambulance, and in autopsy cases. There is also no uniformity among the companies concerning the first and second limits of indemnity, a large proportion of them using the restrictive phrase "any one in-

jured person" rather than the more liberal "any one claim or suit" for the first limit, and some of them failing to define the second limit as the total of all claims paid in any one policy year. With regard to who shall retain and use the right to compromise claims, there are companies who fail to specify whether the policyholder or the insurer shall have that right, and at least one company reserves that right to itself.

Uniform rates do not exist in this line. The nearest approach to uniformity occurs in cases where one company adopts the rates of another because its own loss experience is too limited. Even then it may alter the rates to give them a more favorable competitive position.

In establishing rates, a number of bases are used. Among those found most often are the division of hospitals by legal status, by size, by location as to metropolitan or rural, and by the type of medical care given. Since actuarial data of a comprehensive nature are lacking, judgment plays an important part in determining the rates. But the judgment is not always logically sound. Neglecting the amounts charged and examining the bases of charges, the salient errors in reasoning may be noted. Bed charge is made, as a rule, on the basis of total capacity and only occasionally on the basis of occupancy, although risk can scarcely be associated with empty beds. Other charges are made for physicians and surgeons, pharmacists, etc., on the assumption that, the more of these skilled workers there are, the greater will be the risk. Examined rationally, the payment of \$5.00 or \$10.00 by the hospital for each added doctor or pharmacist, when the bed capacity remains constant, becomes a penalty for having a full complement of professional workers caring for the pa-

tients. The more desirable method of computing rates would be that used by a few companies where charges for the inpatients are made on the basis of beds in the hospital or, better still, on the average number of beds occupied, and charges for ambulatory patients on the basis of visits to the out-patient department.

Since hospitals, taken individually, do not have a sufficiently large number of claims to make any sound critical analyses, they have never had an opportunity to study the relative importance of some types of claims over others. Among the underwriters only a few have sufficient claim information to engage in studies of the frequency of specific causes of malpractice. Data from one of the large carriers have been presented showing the nature of the claim, the cost involved as related to the loss paid and expense paid, the degree of deferment, and the disposition of the claim. A study of the data showed burns of all kinds and nursing errors to be the most expensive causes of malpractice—in fact, proportionately so expensive that preventive action on the part of hospital administrators would seem to be clearly indicated. Deferment of claims presents serious problems to the hospital and the insurer. They are usually difficult to defend (1) because interns and nurses, particularly students, may have left the hospital in the past few years and the medical record not tell the whole story and (2) because it is difficult to fix rates when accidents which occurred several years ago materialize as claims which must be defended, regardless of whether or not the insurance company is still insuring the hospital at the present time. The tremendous variation in losses between hospitals approved by the American College of Surgeons and those not approved, amounting to five

times for the latter over the former, results in the approved hospitals' being penalized in their premium payments to cover the excessive losses of those not approved.

Finally, some comment should be made concerning the fact that very few insurance companies are familiar with hospital administration problems and practices. Suggestions have been made by men in the companies and in insurance departments that the exchange of information among the companies would be desirable and beneficial, but as yet reciprocity is limited. Some concerns do not wish to divulge their hard-earned findings and information in this field to others who presumably would derive

unearned benefits upon which they might realize some financial gain.

In conclusion it must be remembered that hospital malpractice insurance, although a vital need to the hospital, is a minor consideration to insurance companies, who write much larger volumes of other lines and treat hospital malpractice insurance as a more or less unwelcome accommodation line. Perhaps the only real improvement in the present situation will be effected through the exchange of information between the insurance companies and the hospitals, interpreting hospital administration and organization problems to insurance companies and, conversely, the insurance company's problems to the hospital.

APPENDIX A

SPECIMEN APPLICATION¹

DECLARATIONS

1. Full names of Hospital and/or other Assured.....
2. Address.....
(Give Street, County and State)
3. Is Assured an Individual, Co-partnership, Corporation or Estate?.....
4. Is Hospital maintained in whole or in part by public or private funds or endowment?.....
5. Is Hospital operated for profit?.....
6. Is it approved by the American College of Surgeons?.....
Date of Approval.....
7. Are there any claims or suits for alleged malpractice, pending or closed, against the Assured?
..... If so, give details.....
8. Has any Company cancelled or declined to issue Hospital Liability insurance?.....
If so, name Company.....
9. What classes of patients are treated? (Mark out those not treated) General, Medical, Surgical,
Tubercular, Communicable, Insanity, Drug Addicts, Alcoholics, (any special).....

STAFF

10. Give names of Staff (not employes of Hospital) and their specialties.....

CLINICS

11. Are Clinics maintained?.....If so, state kind.....Are they free, part-pay or
full pay?.....State average number of Clinic Physicians and Interns.....
Nurses.....Average number of Yearly Patients.....

EMPLOYES

12. State how many persons are employed by the Hospital in each of the following classifications:
Physicians, Surgeons, Dentists and licensed Interns.....
Unlicensed Interns.....X-ray Technicians.....Laboratory Technicians.....
Pharmacists—Graduate Nurses, Day.....Night.....Under-
graduate or Student Nurses, Day.....Night.....“Practical” Nurses, Day.....
Night.....Is there a Nurses’ Training School?.....

BEDS

13. How many full-pay and part-pay Beds maintained?.....Charity Beds?.....
Bassinettes for maternity cases?.....(Do not include with Beds.)
14. Give last year’s average Bed occupancy?.....%
Bassinette occupancy?.....%

¹ Permission to reproduce contract granted by company.

X-RAY AND RADIUM

15. Does Hospital use X-ray for diagnosis?
 For treatment?

16. Name Physician in charge of X-ray.

17. Does Hospital own or rent Radium? If so, by whom are Radium treatments
 given?

The answers to the foregoing questions are complete and correct to the best of my knowledge
 and belief. My official position with the Hospital is

Date of Application.....194.....

[Signed]

Limits of Liability of Policy—1st Limit \$

2nd limit \$

Policy Period from194.....to.....194....

Total Annual Premium..... (\$.....) Dollars.

Minimum Premium \$

APPENDIX B
SPECIMEN CONTRACT¹

THE COMPANY OF [CITY], [STATE]

A STOCK COMPANY
(HEREIN CALLED THE COMPANY)

Does Hereby Agree with the Assured named in the Declarations, made a part hereof, (and the protection afforded by this policy shall extend to the estate of the Assured), in consideration of the payment of the premium and of the statements contained in the Declarations, subject to the terms, limits, conditions and exclusions of this policy:

AGREEMENTS

INSURANCE COVERAGE

No. 1. *Injury to Patient*

TO PAY on behalf of the Assured all claims for damages (including counterclaims in suits brought by the Assured to collect fees or other charges) for which the Assured is legally liable:

- (a) arising from from injuries sustained by any person while receiving professional treatment in the hospital of the Assured, its outpatient department, or in any ambulance maintained by the hospital on account of malpractice, negligence, any omission, mistake, or the dispensing of drugs or medicines;
- (b) arising from any autopsy, inquest, or personal restraint occurring in any of said places; committed or performed by the Assured or any employe of the Assured during the policy period.

No. 2. *Defense*

TO DEFEND in the name and on behalf of the Assured all suits brought against the Assured, seeking to enforce such claims even if groundless, false or fraudulent.

No. 3. *Expenses*

TO PAY, irrespective of the limit of liability stated in the policy, all costs, all premiums on attachment and appeal bonds, taxed against the Assured or required in any such proceedings, all expense incurred by the Company, and all interest accruing after the entry of judgment upon such part thereof as shall not be in excess of the limit of the Company's liability. However, the Company shall have no liability hereunder for anything incurred or accruing after it has paid, tendered, or deposited in court the amount of such judgment or such part thereof as does not exceed the limit of the Company's liability. However, the Company shall have no liability hereunder for anything incurred or accruing after it has paid, tendered, or deposited in court the amount of such judgment or such part thereof as does not exceed the limit of the Company's liability, as expressed in the policy.

SETTLEMENT OF CLAIMS

The Company shall not settle or compromise any claim or suit without the written consent of the Assured.

LIMITS OF LIABILITY

The Company's total liability for damages for each injured patient shall be limited to the amount as specified as the first limit in the Declarations. Subject to the same limit for each injured patient, the Company's total liability during one policy year shall be limited to the amount as specified as the second limit in the Declarations.

¹ Permission to reproduce contract granted by company.

EXCLUSIONS

The Company shall not be liable for damages caused by any person giving treatment while under the influence of intoxicants or drugs, or while engaged in or in consequence of the performance of an unlawful act, or caused by negligence in the operation or maintenance of any ambulance.

CONDITIONS

This policy is subject to the following conditions:

A. *Report of Claim or Suit*

The Assured, in the event of receiving notice of claim or suit shall advise the Company or its agent or branch office immediately, and thereafter shall immediately forward to the Company's representative any summons or process served, or any information received.

B. *Co-operation—Assumption of Liability*

The Assured shall co-operate with the Company, and upon the Company's request shall insist in effecting settlement (provided the Assured, in writing, has previously consented to such settlement), the securing of evidence and attendance of witnesses, but the Assured shall not interfere in any proceedings of the Company, and unless authorized by the Company in writing, shall not settle any claim or judgment, voluntarily make any payment, assume or admit any liability, nor incur any expense except at his own cost.

C. *Bankruptcy or Insolvency—Action against Company*

Bankruptcy or insolvency of the Assured shall not relieve the Company of its obligations hereunder. Any person or his legal representatives who shall obtain final judgment against the Assured on account of a claim covered by this policy and whose execution against the Assured is returned unsatisfied because of such bankruptcy or insolvency, may proceed against the Company under the terms of this policy to recover the amount of such judgment, either at law or in equity, but not exceeding the limit of this policy applicable thereto. Nothing in this policy shall give to any person or persons claiming damages against the Assured any right of action against the Company except as provided in this Condition.

D. *Other Insurance*

If the Assured has other insurance covering a loss or expense covered hereby, the Company shall be liable only for the proportion of such loss or expense which the sum hereby insured bears to the whole amount of valid and collectible insurance.

E. *Determination of Company's Liability—Time for Suit*

No action, whether brought by the Assured or any other person, shall lie against the Company to recover for any loss alleged to be covered by this policy until the amount of such loss is made certain, either by final judgment against the Assured after trial of the issue or by agreement with the person or persons making claim against the Assured, nor in any event unless suit is instituted within two years after the date of such judgment agreement.

F. *Subrogation*

In the event of any payment under this policy, and to the extent of such payment, the Company shall be subrogated to all the Assured's rights of recovery therefor, and the Assured shall execute all papers required and shall co-operate with the Company to secure such rights.

G. *Assignment or Change of Interest*

No assignment of interest under this policy shall bind the Company until its consent is endorsed hereon. If the death, bankruptcy, or insolvency of the Assured shall occur during the policy period, this policy shall cover the legal representatives of the Assured during the unexpired portion of such period.

H. *Cancellation*

This policy may be cancelled either by the Assured or the Company upon written notice to the other stating the date thereafter when such cancellation shall be effective, and thereupon such date shall be the end of the policy period. Such cancellation by the Company may be effected with or without tender of the unearned premium. The mailing or leaving of a notice to the Assured at the address shown in the Declarations stating the effective date of cancellation (which shall not be less than five days from the time when such notice, in the ordinary course of mail, would have been received at said address or from the time when such notice is left as aforesaid) shall be sufficient to terminate the policy. If cancelled by the Assured, the Com-

pany shall be entitled to an earned premium based on the short-rate cancellation table printed hereon, which shall not be less than the Minimum Premium specified in the Declarations, otherwise the earned premium shall be computed pro rata. The unearned portion of the paid premium so determined (if not tendered) will be refunded to the Assured on demand.

I. *Two or More Assured—Notices and Endorsements*

If this policy covers more than one Assured, any endorsement or rider which in any way extends, restricts or modifies the policy, and all notices required by or relating to the policy, its cancellation, suspension, or reinstatement, may be sent to or served upon any one of the Assured, and thereupon shall be binding on all the Assured.

J. *Statutory Provisions*

Any specific statutory provision in force in the State, the law of which governs this policy, shall supersede any provision in this policy inconsistent therewith.

K. *Policy Changes*

The terms of this policy shall not be waived or altered except by endorsement attached hereto and signed by an executive officer of the Company; nor shall notice to any agent, or knowledge possessed by any agent, or by any other person, be held to effect a waiver or change in any part of this policy.

L. *Misrepresentation*

This entire policy shall be void if the Assured has concealed or misrepresented any material fact or circumstances concerning this insurance or the subject thereof, or in case of any fraud, attempted fraud, or false swearing by the Assured, touching any matter relating to this insurance or the subject thereof, whether before or after a loss.

In Witness Whereof, The Company of [City], [State] has caused this policy to be signed by its President and its Secretary, but the same shall not be binding upon the Company until countersigned by a duly authorized representative of the Company.

SECRETARY

PRESIDENT

COUNTERSIGNED.....

Authorized Representative

APPENDIX C

GLOSSARY OF LEGAL TERMS

"Malpractice" is defined as "the negligent performance by a physician or surgeon of the duties which are devolved upon him by virtue of his contractual relations with his patients; bad or unskillful practice by a physician or surgeon whereby the patient is injured."¹ The definition can be made to hold for hospitals by inserting "hospital employee" in place of "physician or surgeon."

"A tort is a civil wrong founded upon some breach of duty. This duty may arise from contract or it may be one which the law imposes."² A tort is considered to be a legal concept possessing essentially the following characteristics, namely, "(1) a civil right not in itself consensual in character although sometimes connected with, or even arising from, a consensual transaction; (2) a violation of such right, by omission or commission, resulting in the breach of a civil duty; (3) damage resulting from the breach of the duty which is of such a character as to afford a right of redress at law."³

A "tortfeasor" is a person through whose fault or neglect another person is injured. "A failure to use due care resulting in injury to another is called negligence, and gives rise to an action for damages."⁴

The "insurance carrier" (generally called the company) is the individual or organization which, in return for a consideration, agrees to

protect the insured against specified financial losses and, in many cases, to render specified services incidental to such losses.⁵

"The Assured is the person, firm or corporation named in the policy. There may be several Assured named if there are more than one having an insurable interest as owners or part owners of the hospital."⁶

"Person" means a natural person, partnership, association, or corporation.

"Practitioner" means a person licensed to treat and prescribe for human ailments under the States' Medical Practice Act.

"Hospital" means a "person" who maintains an establishment in which sick and injured persons are given medical and surgical care.

"Patient" means an injured or sick person who has come or been sent for relief or care to a practitioner or hospital rendering service.

"Service" means personal and professional service, and food, lodging, ambulance transportation, medical supplies and appliances, and whatever else is reasonably necessary for the care, treatment, and maintenance of a patient.

"Claims" means, unless the context otherwise requires, the claims of a patient (a) for damages from a tortfeasor or (b) for benefits from an insurer.

"Injury" means impairment of bodily, nervous, or mental integrity or health.

⁵ G. F. Michelbacher, *Casualty Insurance Principles* (New York: McGraw-Hill Book Co., 1930), p. 15.

⁶ From rate manual of insurance company.

¹ 48 *Corpus juris* 1112.

² L. P. Stryker, *Courts and Doctors* (New York: Macmillan Co., 1932), p. 45.

³ 62 *Corpus juris* 1091. ⁴ *Ibid.*, p. 45.

APPENDIX D

ILLUSTRATIVE MALPRACTICE CLAIMS¹

CASE A

An operation for cholecystitis was performed at X..... Hospital of Minnesota in January, 1933. The patient died during the following June. An autopsy showed the primary cause of death to be an intestinal obstruction. A surgical sponge had been left in the incision. Suit was filed against the operating surgeon and the hospital for damages of \$7,500 each. A preliminary investigation indicated probable carelessness on the part of the operating-room nurses and vague recollection concerning the sponge count. It was felt that a trial would result in a verdict against the hospital and not against the surgeon. A compromise settlement of \$4,500 was effected, and both suits were dropped.

This case illustrates the need for judgment in deciding when to go to court, since it is quite probable that the hospital would have been held liable for the negligence of its employed nurses.

CASE B

A patient undergoing an operation at a sanitarium in Louisiana was burned by an overheated hot water bottle while unconscious from an anesthetic. The hot water bottle was applied by two student nurses employed by the hospital. Fortunately, the burns were not severe and recovery was satisfactory. When suit was threatened, the insurance company's attorney effected a settlement by the payment of \$242. If this claim had gone to trial, it would likely have produced a verdict for a larger amount, as the negligence was evident.

This case illustrates a common cause of malpractice claims. It further brings out the fact that in Louisiana charitable institutions, such as the hospital in question, have been held to be responsible for the acts of their employees.

CASE C

A patient was treated for acute alcoholism at the X..... Hospital of Georgia in November,

¹ Reproduced by permission of insurance company.

1930. He was dismissed after two or three days but was shortly readmitted, suffering from the same condition. During his second stay at the hospital he also underwent an operation for hemorrhoids. In November, 1932, he brought suit against the hospital for \$50,000, alleging that while in the institution he fell out of bed while partly under the influence of anesthetics or narcotics. As a result of the fall his radius was fractured, recovery was prolonged, and an arthritic condition developed. He claimed that the hospital was liable because of negligent attendance.

No record of the fall was known to the hospital. The patient had been in charge of private nurses. It was therefore believed that no liability could be established against the hospital.

The case was tried in January, 1933. The evidence was given to the jury and a verdict returned in favor of the defendant. The expense for investigation and witness and attorney fees for the defendant amounted to over \$500. This expense was paid by the company in accordance with the terms of the policy.

CASE D

In April, 1933, a child born at the X..... Hospital of California was severely burned by a hot water bottle immediately after delivery by the negligence and carelessness of a registered nurse employed by the institution. The burns healed in the course of several months, but one, a third-degree injury, left a permanent scar. Suit was threatened, and, as a verdict against the hospital was probable, a compromise settlement of \$750 was effected the following August.

CASE E

In July, 1932, a woman came for a general physical examination to a private clinic and hospital in Texas owned and operated by Dr. X..... with several associated physicians and surgeons. Dr. X....., a surgeon, discovered the remains of a small malignant cyst behind the

left ear of the patient, a part of the cyst which had been excised several years before. He recommended an operation to clear up the condition. This was undergone a few days later.

Suit against the doctor and the hospital was filed in March, 1933, alleging that the operation was unnecessary; that, in performing it, certain glands were removed; that the facial nerves were severed; and that the operation upon these glands and nerves was contrary to the patient's consent. Prior to the operation she was earning approximately \$350 a month. Total and permanent paralysis of the facial muscles resulted, and great mental shock and physical debility totally destroyed earning powers. Damages of \$50,000 were asked.

The case attracted wide attention, as the doctor and the hospital and clinic were outstanding in the state. Preparation for the trial involved a great deal of work. Volumes of testimony were gathered and numerous witnesses, medical and lay, were required. The trial took place in January, 1934. When the case was given to the jury, it returned a verdict in favor of the defendants on each count. A motion for retrial was met and defeated in a hearing the following week.

The expenses for attorneys and witnesses amounted to more than \$2,000, the trial having lasted five days.

CASE F

An elderly patient with a fractured femur was taken to the X..... Hospital of Tennessee in December, 1931. An X-ray showed an intracapsular fracture of the right hip. A Whitman cast was applied using a metal device for holding the fracture in opposition and an iron bar set in the cast at each end to keep the legs apart. A number of days later the patient was removed to his home. Instructions were given to a physician not connected with the sanitarium but who was to have charge of the case to have the patient remain in bed for three months with the cast in place. Then the cast was to be removed, but the patient kept in bed for another month with the hip supported with sand bags. During the following six months the patient was to use crutches and during that time avoid any weight on the injured leg.

All of these instructions were apparently disregarded. The physician was never called upon by the patient. The cast was removed by the man's son soon after he returned home and

he began immediately to go about on crutches. The fracture healed with a permanent shortening of about one inch, resulting in impairment of motion. It was felt by all the doctors consulted that the man, considering his age, was fortunate to have obtained any union at all. However, he proceeded to bring suit against the sanitarium in January, 1933, for \$20,000, alleging incompetent treatment, particularly after he left the institution. The case was tried in January, 1934, and the court, after hearing the evidence supported by expert testimony, directed a verdict in favor of the defendant.

CASE G

A woman patient was admitted to the X..... Hospital of New York in October, 1929, and underwent a tonsillectomy. The operation was uneventful, but during convalescence the patient complained of an injured left eye which was examined and treated by an oculist who said that he found an abrasion of the cornea. Later the patient filed suit for \$5,000 damages against the hospital, alleging that the injury was caused by ether dropping into the eye during the administration of the anesthetic and resulted in definite and permanent impairment.

The suit was tried in October, 1934. Testimony given by the defense indicated that an examination of the patient's eyes showed them perfectly normal six months after the operation, that the injury was an abrasion and not an ether burn, and that it was probably due to the patient's own act subsequent to coming out of the anesthetic. The jury returned a verdict in favor of the defendant.

CASE H

An employee in a gin mill in Texas had his right hand badly crushed and lacerated in a piece of ginning machinery. He was taken to the X..... Hospital, where the hand was amputated. This occurred in October, 1929. Suit was filed in September, 1931, against the doctor who performed the operation and who owned the hospital. It was claimed that consent to amputation and consent to a general anesthetic were not given and, finally, that the amputation was carelessly performed, requiring a second operation by another surgeon to correct a painful result. Damages amounting to \$63,800 were asked. The case was finally tried in June, 1933, after many postponements. The trial occupied four days, and attorney's fees and

other expenses amounted to over \$1,000. The jury returned a verdict in favor of the defendant on every count.

CASE I

The X..... Corporation, a small private hospital for surgical cases only, located in California, received a woman patient in March, 1931, for certain examinations and surgical treatment. The latter was to be performed by her own physician. A hypodermic was ordered

by this physician and administered by a nurse employed by the hospital. Suit was filed in October, 1931, asking \$25,550 damages and alleging a prolonged and possibly permanent impairment of a finger. The plaintiff had been a stenographer previous to the disability. The attending surgeon was named as co-defendant, but he was not insured by the company. Therefore, the company's attorneys proceeded with the defense of the hospital and were able to have the suit dismissed in August, 1933.

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